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OCHAMPUS MANUAL 6010.47-M

CHANGES 1 THROUGH 39 HAVE BEEN INCORPORATED

CHAMPUS POLICY MANUAL

VOLUME ONE
(Benefits)

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DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA

CHAMPUS

OFFICE OF THE CIVILIAN HEALTH AND MEDICAL
PROGRAM OF THE UNIFORMED SERVICES

AURORA, CO 80045

October 1982

D1.6/2:

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
AURORA, COLORADO 80045

PDP

6010.47-M
October 7, 1982

FOREWORD

This manual is authorized by OCHAMPUS Instruction 6010.47, CHAMPUS Policy Manual," and provides guidance, policy interpretations and decisions implementing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

The policies and procedures described, herein, apply to the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and each fiscal intermediary (medical) (FI) contractually administrating and processing CHAMPUS medical claims under OCHAMPUS Manual 6010.24-M, "CHAMPUS Opeations Manual: Fiscal Intermediary (Medical)."

Each FI shall implement and be guided by this manual if so directed by the Contracting Officer. FI's which have contracts referencing other instructions will continue to use those instructions referenced in their contracts.

Unless otherwise directed, OCHAMPUS Europe and FI's processing claims for services received in foreign countries shall use the manual for guidance.

Those OCHAMPUS directives and instructions superseded by this manual are listed in Appendix A of Volume One.

Comments regarding the manual should be sent to:

Policy Division
OCHAMPUS
Aurora, Colorado 80045

Keith W Curtis

Keith W. Curtis
Colonel, USAF, MSC
Deputy Director

READEX best copy available

INTRODUCTION

CHAMPUS POLICY MANUAL

VOLUME ONE - BENEFITS

INTRODUCTION

Volume One of the CHAMPUS Policy Manual contains the Program policy interpretations that, with the CHAMPUS Regulation, govern the administration of the program's benefits. It explains what services are covered, to what extent they are covered, and what exceptions, limitations and requirements apply.

ORGANIZATION OF THE MANUAL

Volume One is organized, as much as possible, according to the Current Procedural Terminology, (fourth edition CPT 4). The chapters are arranged as follows:

- Chapter 1 - Medical Services
- Chapter 2 - Anesthesia
- Chapter 3 - Surgery and Related Services
- Chapter 4 - Radiology
- Chapter 5 - Pathology and Laboratory Services
- Chapter 6 - Institutional Services
- Chapter 7 - Other Services
- Chapter 8 - Special Benefit Information

FORMAT

Section 1. of each chapter contains general policy on the subject of the chapter. These policies cover services for which there is not a specific procedure code or they cover a general topic which includes many services.

Page numbering is according to the CPT procedure code of the service to which the policy applies. For example, a policy under procedure code 92120 which is the first policy page under that section and is the first page of the policy would be numbered 92120.1.1. The first .1 meaning the first policy, the second .1 meaning the first page of that particular policy interpretation. Page 2 would be shown as 92120.1.2. If it were the second policy interpretation in that section it would be numbered 92120.2.2.

We have concluded that this organization and format will be the most useful for the users of the manual, including claims examiners. The particular page format will make revisions easier than would a continuous narrative format. Policies for specific procedures can be found on pages numbered with the CPT 4 procedure code.

APPLICABILITY

This volume applies to both Fiscal Intermediaries and to OCHAMPUS. Unless otherwise stated, the policies in the volume apply to all claims, both Basic Program and Program for the Handicapped and to all medical settings, both inpatient and outpatient.

USING THE MANUAL

The policies published in this manual take precedence over any local or internal policy of the fiscal intermediary or other claims adjudicator. Chapter IV, G. of the CHAMPUS Regulation specifically excludes coverage for services and supplies not listed in the Regulation unless the Director, OCHAMPUS, determines that the service or supply is covered within the intent of the Regulation. This manual is the vehicle by which the Director determines that services and supplies are covered.

Therefore, if this manual is silent on an issue, a request for benefit determination must be submitted for a determination by the Policy Division, OCHAMPUS before benefits can be paid. The decision whether to suspend or deny the claim in question while a policy is being developed is left to the fiscal intermediary or other claims adjudicator. Ordinarily, development of a new policy will require a minimum of 90 days.

No Program policy is effective until it is officially published in the Regulation or in this manual. The effective date of a policy guidance is the date of signature unless otherwise specified.

(Note: Until the actual implementation of this manual is completed, FI's are to continue to follow previously issued policy unless specifically superceded by the policy manual. FI's will be informed when implementation is completed.)

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CHAPTER 1

MEDICAL CARE

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Subject: SEXUAL DYSFUNCTIONS AND SEXUAL INADEQUACY	Chapter: 1 Section: 1
Authority: DoD 6010.8-R, Chapter IV, G.30. *	Page: 1.1.1 *
Approval: Deputy Director	Date: November 1, 1983

DESCRIPTION

Sexual dysfunction or sexual inadequacy refers to a problem of sexual performance or sexual orientation. It does not include infertility.

POLICY

CHAMPUS funds are not authorized for any service and or supply related to sexual dysfunction or sexual inadequacy regardless of whether it is medical, surgical, psychiatric, drug, mechanical, or other such service.

Subject: OFFICE VISITS - GENERAL	Chapter: 1 Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.2.d.	Page: 90000.1.1
Approval: Keith W Curtis	Date: APR 19 1983

PROCEDURE CODE RANGE 90000 - 90080

POLICY

Office visits are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms. Visits are classified according to the following levels:

Minimal service

Brief service

Limited service

Intermediate service

Extended service

Comprehensive service

Visits are also classified according to whether the patient is new or is an established patient. Only one new patient visit for a beneficiary to a provider is covered.

If the claim does not specify the level of the visit, the service will be considered a limited service visit. If the claim does not specify whether the patient is new or established, the patient will be considered to be an established patient.

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EXCEPTIONS

1. Office visits for the purpose of a routine physical examination are not covered. See Page 90000.3.1.

2. For patients who have been determined to be receiving custodial care, office visits related to the custodial condition are not covered.

POLICY CONSIDERATIONS

No additional payment will be allowed when any of the below listed services are billed in conjunction with an office visit. Reimbursement will be limited to the allowable charge for the office visit only (combine the charges and base payment on the maximum allowable charge for the office visit.) If the level of the visit is not specified, the visit will be considered to be a limited service visit (90050).

Minor dressing.

Oscillometric testing.

Ostomy care.

Prostate massage.

Blood pressure determination.

Topical 5 FU treatment.

Eye washing.

Ear irrigation.

Pelvic examination.

Rectal examination.

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Urethral catheterization.

Insertion of Foley catheter.

Removal of fecal impaction.

Eye examination (pay according to the appropriate code for the eye examination 92002 - 92499; disallow any additional charge for an office visit.)

Glaucoma or cataract check.

Removal of cerumen.

Cauterization of cervix by chemical agents.

Subject: OFFICE VISITS WITH SURGERY	Chapter: 1 Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.2.d.	Page: 90000.2.1
Approval: Keith W Curtis	Date: APR 19 1983

PROCEDURE CODE RANGE	90000 - 90080
DESCRIPTION	When surgery is performed at the time of the initial office visit.
POLICY	1. When a surgical procedure is performed at the time of an initial office visit (90000 - 90020), both the office visit and the surgical procedure are covered. 2. A follow-up office visit performed on the same day as surgery is not covered unless it was required for a separate diagnosis.

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Subject: HOME VISITS	Chapter: 1 Section: 3
Authority: DoD 6010.8-R, Chapter IV, C.2.d.	Page: 90100.1.1
Approval:	Date: APR 19 1983

PROCEDURE CODE RANGE	90100 - 90170
DESCRIPTION	Visits provided by an individual professional provider for beneficiaries who are home bound.
POLICY	Home visits are covered when provided by an individual professional provider for the diagnosis or treatment of a covered condition for beneficiaries who are home bound or whose condition is such that home visits are indicated.
POLICY CONSIDERATIONS	If the patient has been determined to be receiving custodial care, home visits are covered only when provided by a visiting nurse for up to one hour per day for skilled nursing care. Visits by a physician for care of the custodial condition are not covered. See Chapter 8, * Section 5, Page 5.1.1, of this Volume One, entitled* * "Private Duty Nursing: Hospital with Specialized * * ICU." *

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Subject: INITIAL HOSPITAL VISITS	Chapter: 1 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.2.c.	Page: 90200.1.1
Approval: Keith W Curtis	Date: APR 13 [illegible]

PROCEDURE CODE RANGE	90200 - 90220
DESCRIPTION	An initial hospital visit includes the history, physical examination, development and initiation of a diagnostic and treatment plan, and review and assessment of prior data and records.
POLICY	An initial hospital visit is covered when provided by an individual professional provider for a covered hospitalization. Only one initial hospital visit is covered for each hospital stay.
POLICY CONSIDERATIONS	A routine initial hospital visit prior to surgery is generally included in the allowance for the surgical procedure. A separate allowance for the initial hospital visit may be made if: 1. The surgical procedure is designated with an asterisk in the Physicians' Current Procedural Terminology, Fourth Edition; 2. A period of time (at least 72 hours) elapsed between admission and surgery, during which time either diagnostic services were required to establish the need for surgery or the patient's condition was stabilized sufficiently to permit surgery. (See page 90240.2.1 for concurrent care provisions.)

Revision No: Revision Date:

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Subject: PRE AND POST SURGICAL HOSPITAL VISITS	Chapter: 1 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.2.a.	Page: 90200.2.1
Approval: Keith W Carter	Date: APR 19 1983

PROCEDURE CODE RANGE	90200 - 90270
DESCRIPTION	Routine visits that are considered related to the surgical procedure.
POLICY	Routine pre and postoperative visits are included in the global charge for the surgical procedure. No additional allowance may be made for routine pre and postoperative visits.
EXCEPTIONS	1. Surgical procedures designated in the Physicians' Current Procedural Terminology, Fourth Edition, with an asterisk, do not include the pre and postoperative visits in the surgical allowance. The visits are covered on a fee-for-service basis. 2. If a patient is hospitalized for a period of time prior to surgery in order to perform diagnostic services to determine the need for surgery or to permit stabilization of the patient's condition prior to surgery, the presurgical visits are not routine. Payment may be made on a fee-for-service basis. 3. Only routine, uncomplicated follow-up care is included in the surgical allowance. Care required because of complications is covered separate from the surgical allowance.

Revision No: Revision Date:

Subject: FOLLOW-UP HOSPITAL VISITS	Chapter: 1 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.2.c.	Page: 90240.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE 90240 - 90280

DESCRIPTION

1. Follow-up hospital visits are visits subsequent to the initial visit. They include: examination of the patient, assessment of technically acquired data, alteration in the diagnostic or treatment plan, maintainence of hospital records, discussion with the patient and family regarding medical status and the following specific services:

a. Routine administration of blood, plasma, and intravenous fluids, except in patients under three years of age;

b. Evaluation of laboratory and x-ray reports;

c. Application or changing of dressings;

d. Reviewing progress and nursing notes;

e. Writing orders.

POLICY

1. Hospital visits are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms. Visits are classified according to the following levels:

a. Brief service

b. Limited service

-Continued-

c. Intermediate service

d. Extended service

e. Comprehensive service.

2. If the claim does not specify the level of the visit, the service will be considered a limited service visit (90250).

3. More than one hospital visit on the same day by the same provider to a patient is not covered unless the FI's medical review staff determines that multiple visits are appropriate. * * * * See page 99160.1.1 of this Chapter 1 for an exception to this policy in critical care situations. * * * *

4. A hospital visit on the final day (90292) includes examination of the patient, discussion of the illness and prognosis, instructions for continuing care and completion of the hospital and insurance records. No additional charge is payable for the hospital discharge summary.

5. No payment may be made for discharging a patient by telephone.

POLICY CONSIDERATIONS

1. Hospital visits at an intermediate or extended level (90260 - 90270) may be covered for up to seven days. Claims which exceed seven days must be documented as to the medical necessity for the higher level and must be submitted to medical review. Claims which do not contain the required documentation will be processed as limited visits (90250).

Subject: INPATIENT CONCURRENT CARE	Chapter: 1
	Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.3.b. and f.	Page: 90240.2.1
Approval:	Date: APR 19 1983

DESCRIPTION

Concurrent care exists where services more extensive than consultative services are provided by more than one individual professional provider during the same period of time.

POLICY

1. If, during the same admission, a beneficiary receives care from more than one individual professional provider, the services of the providers may be covered if the severity of the beneficiary's condition warranted the concurrent care.

2. If the providers are of the same specialty, the claim must be submitted to medical review to assure that the beneficiary's condition is of a severity to justify the concurrent care.

3. In the absence of such a determination, benefits are payable only for the services of the attending provider.

4. If the patient receives medical care and surgical/maternity care from the same provider during the same hospitalization, only the type of care with the higher total charge is covered.

-Continued-

5. If the patient receives medical care and surgical/maternity care from different providers for the same diagnosis, see 1 and 2, above. If the care is provided by different providers for different diagnoses, the services are covered if medically necessary.

Subject: SKILLED NURSING FACILITY VISITS	Chapter: 1
	Section: 5
Authority: DoD 6010.8-R, Chapter IV, C.2.c.	Page: 90300.1.1
Approval: Keith W Curtis	Date: April 19, 1983

PROCEDURE CODE RANGE

90300 - 90370

POLICY

Visits to a skilled nursing facility are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms. Visits are classified according to the following levels:

Brief service

Limited service

Intermediate service

Extended service

Comprehensive service

Visits are also classified according to whether the visit is the initial visit to that patient at the skilled nursing facility or is a follow-up visit. Only one initial visit to a patient by a provider is covered.

If the claim does not specify the level of the visit, the service will be considered a limited service visit. If the claim does not specify whether the visit is an initial visit or a follow-up visit, it will be assumed to be a follow-up visit.

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Revision No: 1	Revision Date: NOV 01 1983

POLICY CONSIDERATIONS

Initial skilled nursing facility care of a patient transferred from a hospital by the same physician on the day of hospital discharge is payable only if no hospital visit was billed for the final day of hospitalization.

* If a hospital visit was not billed for the final day, the initial skilled nursing facility visit will be processed as a brief service (90300). *

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Subject: NURSING HOME VISITS	Chapter: 1 Section: 6
Authority: DoD 6010.8-R, Chapter IV, C.2.c.	Page: 90400.1.1
Approval: Keith W Carter	Date: APR 19 1983

PROCEDURE CODE RANGE

90400 - 90470

POLICY

Visits by an individual professional provider to patients in nursing homes are covered if both the following conditions are met:

1. The visit is medically necessary for the diagnosis and treatment of a specific illness or injury; and

2. The patient is not a custodial care patient; or if it has been determined that the patient is receiving custodial care, the nursing home visit and any associated services are for a condition other than the custodial condition.

EXCEPTIONS

Visits to a nursing home which represent authorized skilled nursing care for a custodial patient are covered.

POLICY CONSIDERATIONS

Nursing home visits will be covered according to the guidelines for home visits. See Page 90100.1.1

Revision No: Revision Date:

Subject: EMERGENCY SERVICES	Chapter: 1
	Section: 7
Authority: DoD 6010.8-R, Chapters II, B. and IV, C.2.c.	Page: 90500.1.1
Approval: Deputy Director	Date: February 16, 1983

PROCEDURE CODE RANGE 90500 - 90570

DESCRIPTION

A "medical emergency" means the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition which is threatening to life, limb or sight, and which requires immediate medical or surgical treatment or which involves painful symptomatology requiring immediate palliative efforts to relieve suffering.

POLICY

a. Emergency Services.

(1) Claims for emergency care may be accepted and processed without a nonavailability statement or physician's statement of emergency when one of the following conditions is acutely manifested, requires medically necessary care, and is reflected on the claim form by the designated diagnosis for the condition:

- Heart attacks (including myocardial infraction, cardiac arrythmias, and other serious cardiac disease).
- Convulsion.
- Cerebral vascular accidents.
- Kidney stones.
- Poisoning (includes drug overdose).
- Traumatic injuries (e.g., gunshot wounds, fractures, dislocations, burns, lacerations, contusions, sprains, or strains, etc.).

-Continued-

- Severe allergic reactions.
- Maternity emergency. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication which puts the mother, or baby, or both, at risk. Pain would NOT qualify a maternity case as an emergency; nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident). If a claim or attached document indicates a baby was delivered weighing 5 pounds or less, it may be assumed that delivery occurred before the 35th week of gestation and the claim may be processed as a maternity emergency.

(2) Psychiatric emergency. A psychiatric admission would not normally be considered as an emergency. To be considered a psychiatric emergency, an exceptional case must meet the following criteria as a minimum:

(a) A DSM-III diagnosis where there is a significant distress and dysfunction (this by itself would not suffice) and,

(b) The patient is a real and present significant risk to self or danger to others and this is manifested by a life threatening condition. For

-Continued-

* example, a patient is threatening suicide *
* and if he or she is not put under control *
surveillance immediately, he or she could *
* kill himself or herself. The attending *
* physician's statement is required with a *
* certification as to the life threatening *
* condition that existed. *

(3) Emergency services required as a result of self-inflicted injuries are covered.

(4) Tetanus toxoid, when administered in connection with emergency services related to abrasions, lacerations or puncture wounds, is covered.

(5) A charge in addition to the charge for the emergency room visit is not covered for a provider who is called from outside the hospital to provide emergency services.

b. Medical Review Requirements.

Generally the attending physician determines medical emergency subject to review and verification by the CHAMPUS fiscal intermediary. If an emergency admission diagnosis does not fall within the diagnoses given in paragraph a.(1), above, the case will then be reviewed by the fiscal intermediary medical review staff to determine whether the care meets the definition of medical emergency.

POLICY CONSIDERATIONS

a. Limitations. The following limitations apply in determining whether or not CHAMPUS benefits can be extended for emergency care when a nonavailability statement is normally required.

(1) A planned inpatient admission,

-Continued-

regardless of any other circumstances, will not be considered a medical emergency.

(2) In order to be considered an emergency admission, the civilian hospital must be significantly closer (i.e., in either distance or time, depending on the circumstances) than the Uniformed Services medical facility in relation to the location of the beneficiary at the time the emergency occurred.

(3) Normally a transfer from one hospital to another would not qualify as an emergency admission. Exceptional situations will require a medical review by the fiscal intermediary for a determination of an emergency admission.

(4) Where an emergency admission occurs, CHAMPUS may subsequently exercise its right to require transfer to the nearest Uniformed Services medical facility (assuming space and professional capability are available) when it is determined the emergency has passed. Whether or not the beneficiary accepts transfer, CHAMPUS benefits terminate within 24 hours of the time the transfer request is initiated.

(5) In the case of an emergency maternity admission, if it is determined the attending physician had provided any prenatal care to the patient during her pregnancy (whether or not she was also being provided prenatal care from a Uniformed Services medical facility), CHAMPUS benefits will not be provided without a nonavailability statement regardless of any other circumstances.

(6) In the case of an emergency maternity admission when the patient

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delivers, the CHAMPUS-determined allowance for the maternity care will be limited to the delivery only. No CHAMPUS benefits will be extended for prenatal or postnatal care since that care would not be considered part of the emergency.

(7) Emergency claims for pregnant beneficiaries who travel away from their area of residence will be processed in the same manner as for pregnant beneficiaries located in the residence area. Delivery occurring outside the area of residence will not be considered to be an emergency simply because of distance from the Uniformed Services medical facility.

b. Other Considerations.

(1) If an emergency room visit and initial critical care (99160 - 99062) are billed on the same day, only the charge for the initial critical care is covered.

(2) If an emergency room visit and an initial hospital visit are billed on the same day by the same professional provider, only the visit with higher prevailing charge is payable. If billed by different professional providers, each service is payable.

(3) If an emergency room visit and minor surgical procedure are billed on the same day, each is covered.

(4) Emergency services may be cost-shared as inpatient services if an inpatient admission immediately followed the emergency service. If there is a period of observation following the emergency services to determine if inpatient admission is required, or if the patient goes home and subsequently returns

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to the hospital and is admitted, the emergency services are cost-shared as outpatient services.

(5) Beneficiaries have the right to appeal any adverse determination of medical emergency or its termination.

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Subject: CONSULTATIONS	Chapter: 1
	Section: 8
Authority: DoD 6010.8-R, Chapter IV, C.2.f.	Page: 90600.1.1
Approval: Keith W Curtis	Date: APR 19 1983

PROCEDURE CODE RANGE 90600 - 90630

DESCRIPTION

A consultation is a professional service rendered to a patient by an authorized individual professional provider at the request of the attending physician. A consultation includes a history and examination of one or more organ systems and must result in a written report furnished to the attending physician for inclusion in the patient's permanent medical record.

POLICY

1. Consultations performed by an individual professional provider at the request of the patient's attending provider are covered.

2. Reimbursement for a consultation does not include diagnostic procedures performed by the consultant. Appropriate allowances should be made for such services in addition to the consultation.

EXCEPTIONS

1. A consultation performed within three days of a non-diagnostic surgical procedure by the same physician who performs the surgery is included within the surgical fee. An additional allowance is not covered.

2. Telephone consultations and telephone toll charges are not covered.

-Continued-

3. Staff consultations required by the policies of a hospital or other institution are not covered.

POLICY CONSIDERATIONS

1. Only one consultation, inpatient or outpatient, is covered when provided by the same provider during the course of the patient's illness (i.e., for the same diagnosis), or episode of illness, unless documentation is submitted which demonstrates a change in the patient's condition which affects treatment or prognosis. Such claims require medical review to verify that such a situation exists.

2. Multiple consultations by providers of the same or different specialties are covered when required because of a complex medical condition. If the FI has any doubt about the medical necessity for one or more of the services, consultation reports should be obtained and referred to medical review.

3. Reimbursement for a consultation includes all visits made by the patient to the consultant. A consultation which requires multiple visits should be considered to be a complex consultation. In all such cases, the FI should obtain a copy of the consultation report and assure that the visits are all related to the consultation and that the consultant has not become the attending physician.

4. A copy of the consultation report is not routinely required, although the FI may request the report at any time.

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5. The name and address of the attending physician is required on each claim for a consultation. FIs need not develop for the name and address of the attending physician. Providers are to be advised that if the information is not submitted on the claim, the consultation will be reimbursed only up to the allowable charge for a limited initial visit, new patient (90010).

6. Consultations will be cost-shared according to the status of the patient, inpatient or outpatient, at the time the service is rendered.

Subject: IMMUNIZATION INJECTIONS	Chapter: 1 Section: 9
Authority: DoD 6010.8-R, Chapter IV.G.38	Page: 90701.1.1
Approval: Deputy Director	Date: October 12, 1984

* PROCEDURE CODE RANGE 90701 - 90749 *

DESCRIPTION	The process of rendering a subject immune, most frequently accomplished by immunization with either live or inactivated viral agents or bacterial antigens (active immunization) or by administration of preformed antibody after an exposure to a disease has occurred (passive immunization).
POLICY	Immunizations are not covered except when required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service. (See page 1.1.1 of Chapter 1, Section 1 of this Volume One.) (See page 90751.1.1 of Chapter 1, Section 9 of this Volume One and Part Three, Addendum J of the COM-FI for policy concerning well-baby care routine immunizations.)

Revision No: 1 Revision Date: March 12, 1985

Subject: * PREVENTIVE CARE * *	Chapter: 1
	Section: 10 *
Authority: DoD 6010.8-R, Chapter IV, E.3.b. & G.38 *	Page: 10.1.1 *
Approval: Deputy Director	Date: April 19, 1983

DESCRIPTION

Preventive care is any service performed in the absence of definitive signs, symptoms, or complaints. Examples of preventive care include annual physical examinations, routine immunizations and routine screening procedures.

POLICY

Preventive care is not a benefit of CHAMPUS, except as follows:

EXCEPTIONS

1. Routine physical examinations and routine immunizations are covered when provided to the spouse and children of active duty service members in preparation for official travel outside the United States. A copy of the travel orders must be submitted with the claim. For more information concerning physical examinations see Page 90750.1.1 of this Chapter 1. *

2. Well-baby care from birth to the age of two years is covered. See page 90751.1.1.

3. Routine chest x-rays and routine electrocardiograms required for admission to an inpatient institution are not covered unless the patient is being admitted for a surgical procedure which involves general anesthesia.

4. Cervical pap smears are generally routine screening procedures and are not covered. Payment for a cervical pap smear is authorized in the following circumstances only:

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a. Previous cancer of the cervix, uterus, or vagina.

b. Previous abnormal pap smear.

c. Irritation or inflammation of the cervix.

d. Abnormal vaginal bleeding.

e. Abnormal vaginal discharge.

f. Intrauterine exposure to diethylstilbestrol.

g. As part of the prenatal laboratory workup for a new maternity patient.

* h. As part of the care for women *
* undergoing estrogen replacement therapy. *

5. Tetanus immune globulin (human) and tetanus toxoid administered following an injury are covered.

6. Administration of antirabies serum or human rabies immune globulin and rabies vaccine is covered following an animal bite. Pre-exposure prophylaxis for persons with a high risk of exposure to rabies is not covered.

7. Laboratory examination of the brain of an animal suspected of having rabies is covered if performed by a laboratory which is a CHAMPUS-authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the

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examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

8. Charges by any source for boarding and observation of the animal or destruction of the animal and collection of the brain specimens are not covered.

9. Rh immune globulin is covered when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

10. Gamma globulin is covered only when administered for one of the following biochemical conditions:

Hypogammaglobulinemia
Agammaglobulinemia
Dysgammaglobulinemia

Gamma globulin is not covered when administered following exposure to a viral disease.

11. Genetic testing and counseling is covered only for a pregnant beneficiary and when one of the following circumstances exists:

a. The pregnant woman is 35 years of age of older.

b. One of the parents of the fetus has had a previous child born with a congenital abnormality.

c. One of the parents of the fetus has a history (personal or family) of congenital adnormality.

-Continued-

d. The pregnant woman contracted rubella during the first trimester of the pregnancy.

12. Chromosome analysis in cases of habitual abortion or infertility is considered a diagnostic service and is not subject to the genetic testing criteria.

13. Chromosome analysis of children is considered a diagnostic service and is not subject to the genetic testing criteria. Common indications for chromosome analysis in children include ambiguity of external genitalia, small-for-gestational age infants, multiple anomalies and failure to thrive.

Subject: * ROUTINE PHYSICAL EXAMINATIONS *	Chapter: 1
	Section: 10 *
Authority: * DoD 6010.8-R, Chapter IV, Section G	Page: 90750.1.1 *
Approval: Deputy Director	Date: April 19, 1983

* PROCEDURE CODES:	90750 - 90753; 90760 - 90763; 90774. *
* DESCRIPTION:	A routine physical examination is a medical examination conducted in the absence of a presenting complaint or other indication of illness or injury.
* POLICY:	A routine physical examination is excluded from the CHAMPUS as not medically necessary.
* POLICY CONSIDERATIONS:	1. A physical examination which leads directly to the diagnosis of a diseased condition is not a routine physical examination. 2. A physical examination associated with well baby care is not a routine physical examination. 3. A physical examination provided when required in the case of a dependent of an active duty military member who is traveling outside the United States as a result of the active duty member's assignment and such travel is being performed under orders issued by a Uniformed Service is not a routine physical examination. 4. A physical examination required for an application to the United States Department of State for an immigrant visa is a routine physical examination. 5. An ancillary procedure in support of a routine physical examination is excluded as related to an excluded procedure.

Revision No: 1 Revision Date: February 26, 1986

Subject: WELL-BABY CARE	Chapter: 1 Section: 10
Authority: DoD 6010.8-R, Chapter IV, C.2.m. and C.3.m.	Page: 90751.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODES

90285, 90701-90749, 90753-90755, 90763-90764, 54150, 54160, 81000-81099, 84030-84031, 84035-84037

DESCRIPTION

Well-baby care includes routine newborn care, routine physical examinations, routine immunizations, periodic health screening, and developmental assessment.

POLICY

Well-baby care is covered for beneficiaries from birth to the age of two years, when services are provided by the primary physician or pediatric nurse practitioner.

POLICY CONSIDERATIONS

1. Visits for diagnosis or treatment of an illness or injury are not included in the well-baby benefit. Benefits should be extended on the basis of the medical necessity for the services.

2. For children whose health screening and immunizations may not be current, payment may be made for well-baby visits and immunizations up to midnight of the day prior to the day the child turns two years old. Payment for immunizations will be made strictly in accordance with the following schedule:

    a. Diphtheria, purtussis, tetanus:
        3 doses at 4-8 week intervals
        4th dose 1 year after third

-Continued-

b. Oral Polio:
2 doses at 6-8 week intervals 3rd dose at least 6 weeks and preferably 8-12 months after second.

c. Measles, mumps, rubella:
The child must be at least 12 months of age and preferably 15 months old.

* d. Haemophilus influenzae type B: *
* The child should be between the ages of 18 and 24 months. *
* Effective April 16, 1985. *

3. Well-baby care for newborns includes the routine care of the newborn in the hospital (90285), PKU testing, and newborn circumcision. Only routine well-baby care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share or nonavailability statement is not required for the infant. (See Volume II, Chapter 4, Section 2, page 2.1.3 of the Policy Manual.) If a circumcision is performed after the child has been discharged from the hospital, the service is cost-shared as an outpatient service (unless it qualifies for the special cost-sharing for ambulatory surgery).

4. A program of well-baby care conducted according to the most current Guidelines for Health Supervision, American Academy of Pediatrics, is covered. Significant deviation from the guidelines requires justification. In any case, no more than nine well-baby visits in two years are covered.

5. Each office visit for well-baby care includes the following services:

-Continued-

a. History and physical examination.

b. Developmental and behavioral appraisal.

(1) Measurement of height and weight.

(2) Measurement of head circumference for children under 12 months of age.

(3) Sensory screening: vision, hearing (by history).

(4) Discussion with parents, anticipatory guidance.

6. The following specific procedures are covered in a program of well-baby care:

a. Immunization, according to the schedule in paragraph 2, above.

b. PKU testing: within first two weeks.

c. Tuberculin test: at 12 months of age and once during second year of age.

d. Hemoglobin or hematocrit testing: once during first year of age, once during second year of age.

e. Urinalysis: once during first year of age, once during second year of age.

Subject: BOTULINUM TOXIN A INJECTIONS	Chapter: 1 Section: 11
Authority: DoD 6010.8-R, Chapter IV, D.3.f., G.15.	Page: 90782.1.1
Approval: Deputy Director	Date: 12 Oct 84

DESCRIPTION	This procedure involves the injection of small amounts of Botulinum Toxin A into the extraocular muscles or eyelid muscles. It's used for nonsurgical correction of strabismus and for essential blepharospasm.
POLICY	Botulinum Toxin A has not yet been approved by the Food and Drug Administration. All claims related to its use must be denied as experimental/investigative.

Revision No: Revision Date:

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Subject: VITAMIN B-12 INJECTIONS	Chapter: 1 Section: 11
Authority: DoD 6010.8-R, Chapter IV.B.2.e. & V.H.2.c. *	Page: 90782.2.1 *
Approval: Robert D Seaman for Director	Date: January 23, 1984

PROCEDURE CODE 90782

DESCRIPTION VITAMIN B-12 is essential to cell maturation and when deficient, results in certain characteristic anemias and neurologic disorders.

POLICY Vitamin B-12 injections are covered only for treatment of the following:

1. Anemias secondary to Vitamin B-12 deficiency.
    a. Pernicious anemia.
    b. Megaloblastic anemias.
    c. Macrocytic anemias.
    d. Fish tapeworm anemia.
2. Gastrointestinal disorders resulting in anemias.
    a. Post gastrectomy.
    b. Malabsorption syndromes such as sprue and idiopathic steatorrhea.
    c. Surgical and mechanical disorders such as small intestine resections, strictures, anastomoses and blind loop syndrome.
3. Neuropathies secondary to Vitamin B-12 deficiency.
    a. Posterolateral sclerosis.

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b. Neuropathies associated with pernicious anemia.

c. During the acute phase or exacerbation of the following:

(1) Multiple sclerosis.

(2) Trigeminal and glossopharyngeal neuralgia.

(3) Neuropathies of malnutrition and alcoholism.

(4) Tabes dorsalis.

(5) Causalgia.

(6) Postsympathectomy paresthesias.

(7) Herpes zoster.

(8) Diabetic neuropathy.

(9) Other inflammatory neuritis not due to mechanical or traumatic etiology.

EXCEPTION

Benefits are not covered for Vitamin B-12 injections to strengthen tendons or ligaments of the foot.

Subject: CHELATION THERAPY	Chapter: 1
	Section: 11
Authority: DoD 6010.8-R, Chapter IV, C.2.c., D.3.f. and G.15.	Page: 90784.1.1
Approval: Deputy Director	Date: 12 Oct 84

PROCEDURE CODE 90784

DESCRIPTION The intravenous administration of chelation techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body.

POLICY Chelation therapy (or chemical endarterectomy) using disodium edatate, (EDTA) is considered an experimental/investigational therapeutic modality for the treatment of the following conditions and is not covered.

Multiple sclerosis

Arthritis

Hypoglycemia

Diabetes

Arteriosclerosis

EXCEPTIONS Chelation therapy is covered only when administered in selected cases for the following conditions.

Control of ventricular arrhythmias or heart block associated with digitalis toxicity.

Emergency treatment of hypercalcemia.

Extreme conditions of metal toxicity.

Claims for the above listed conditions will be referred to medical review, to establish that the severity of the patient's condition warranted the use of disodium edatate.

Revision No: Revision Date:

Subject: IMMUNOTHERAPY FOR MALIGNANT DISEASE	Chapter: 1 Section: 11
Authority: DoD 6010.8-R, Chapter IV, G.15	Page: 90799.1.1
Approval: Robert D Seaman for Director	Date: October 12, 1984

* PROCEDURE CODE	90799 *
DESCRIPTION	The treatment of malignant disease by administration of purified antigen, autogenous vaccine, preformed antibodies, purified protein derivatives, "deblocking proteins," immunizing agents, and live bacteria vaccines, etc.
POLICY	Immunotherapy for malignant diseases is considered investigational and is not covered. This exclusion also covers all associated pathology and radiology service performed to determine antibody levels, and all other related services and supplies.

Revision No: 1 Revision Date: August 26, 1985

Subject:
LIMIT ON INPATIENT MENTAL HEALTH CARE

Chapter: 1

Section: 12

Authority:
Pub. L. 97-377, Defense Appropriation Act, Fiscal Year 1983

Page:
12.1.1

Approval: Deputy Director

Date:
December 29, 1982

DESCRIPTION

The Defense Appropriation Act for Fiscal Year 1983 restricts the use of CHAMPUS funds for inpatient mental health services.

POLICY

Effective for inpatient admissions beginning on and after January 1, 1983, no CHAMPUS funds shall be used to pay institutional or professional claims for inpatient mental health services in excess of 60 days in a calendar year.

EFFECTIVE DATE

Inpatient admissions beginning on and after January 1, 1983.

EXCEPTIONS

A. This limit does not apply to:

1. Any services provided under the Program for the Handicapped;

2. Any services provided in a residential treatment center;

3. Any services provided as partial hospitalization (less than 24-hour-a-day care), if such services are covered by CHAMPUS;

4. Any inpatient mental health services rendered to patients admitted before January 1, 1983, provided the patient remains continuously hospitalized and the inpatient care is medically or psychologically necessary. These admissions will continue to be subject to current utilization review procedures.

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B. The patient may request and the Director, OCHAMPUS, may grant coverage for more than 60 days of inpatient mental health services in a year.

POLICY CONSIDERATIONS

A. The Director, OCHAMPUS, taking into account the findings of professional review, will grant coverage in excess of 60 days of inpatient mental health services in a calendar year if the Director finds that:

1. The patient is suffering from an acute mental disorder or acute exacerbation of a chronic mental disorder which results in the patient being put at significant risk to self or of becoming a danger to others; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting;

or

2. The patient has medical complications; and the patient requires a type, level, and intensity of service that can only be provided in an inpatient setting.

B. This policy limiting coverage of inpatient mental health services applies to any inpatient admission in which the patient receives covered services for a diagnosis listed in the Diagnostic and Statistical Manual, 3rd Edition (DSM-III), (including alcoholic and drug abuse/dependence) and to any inpatient admission in which the patient receives covered mental health services, including but not limited to, psychotherapy, electroshock therapy, or administration of psychotropic drugs, regardless of the primary diagnosis.
(NOTE: Some psychotherapy is provided as an incidental part of all accident rehabilitation stays to help the patient adjust to his or her newly acquired dis-

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ability. If psychotherapy is an incidental part of a rehabilitation stay for accident victims or of a medical stay for cancer patients, and the therapy is not intensive or on-going, and does not contribute to the need for an inpatient stay, it can be excluded from consideration under the 60-day limitation.)

1. An inpatient admission for alcohol detoxification and rehabilitation counts toward the 60-day per calendar year limit on inpatient mental health services regardless of whether the patient suffering from alcoholism is admitted to a general hospital or to an alcoholism rehabilitation facility.

2. If a case involves both alcohol abuse/dependence and other DSM-III diagnosis, the 21-day limit would apply if the patient was admitted to an alcoholism rehabilitation facility.

C. This policy applies to the first 60 days of care for which claims are submitted and paid when dealing with multiple providers and to the 61st chronological day of care when a single provider is involved regardless of whether the care is continuous or intermittent during the calendar year.

D. If the patient is hospitalized to receive inpatient mental health services, but the admission is denied as not covered by CHAMPUS, those services will not be considered in determining the number of days of inpatient mental health services used in a calendar year.

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E. If the beneficiary has other coverage that pays in full for inpatient mental health care, those days will not be considered in determining the days of coverage remaining under CHAMPUS. If, however, CHAMPUS pays any amount, or credits any amount to the CHAMPUS deductible, as a secondary payor, each day of that admission will be counted in determining the days of inpatient mental health care remaining, regardless of the amount CHAMPUS pays or credits.

F. If a patient receives inpatient mental health services in excess of 60 days in a calendar year, and no additional coverage is granted by the Director, neither the institutional nor the professional services provided during previous or subsequent hospitalizations for mental health care are payable.

G. The fiscal intermediary shall notify the patient when 30 days of inpatient mental health services have been paid in a calendar year. See COM-FI, Part Two, Chapter 1, Figure 1-40.

H. Information on the number of days of inpatient mental health services which have been paid by CHAMPUS for a particular beneficiary may be released on request to the beneficiary (or to the parent or guardian of a minor or to the guardian of an incompetent adult beneficiary) or to a CHAMPUS-authorized provider that is involved in the care of the beneficiary. The relationship of the requesting party to the beneficiary must be confirmed prior to release of the information.

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I. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not billed during the same calendar year by a different provider. However, the decision may be reopened if the care was rendered by the same provider regardless of whether the stay was continuous or intermittent. The beneficiary will be liable for any inpatient mental health care in excess of the 60 days per calendar year except when a waiver is granted by the director, OCHAMPUS, or a designee.

J. Denial of inpatient mental health services in excess of 60 days in a calendar year is not appealable. Denial of a request for additional days of coverage because the patient does not meet the criteria in POLICY CONSIDERATIONS, above, is appealable.

K. All requests for coverage of inpatient mental health service in excess of 60 days in a calendar year must be submitted by the beneficiary, or by the parent or guardian of a minor, the guardian of an incompetent beneficiary or by an attending physician on behalf of the beneficiary.

L. The request is to be submitted to the Office of Quality Assurance, OCHAMPUS, Aurora, Colorado 80045. (See COM-FI, Part Two, Chapter 1, Figure 1-41.) The Office shall:

1. Review the documentation submitted.

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2. Deny those requests which clearly do not meet the requirements of the criteria for reviewing requests for waiver, set forth in this policy. These criteria shall be used both by the Office of Quality Assurance staff and by professional reviewers as guidance in the review of requests for additional coverage in excess of 60 days.

3. Arrange for timely and appropriate professional review of claims.

4. Determine whether to approve additional coverage in excess of 60 days in a calendar year.

5. Obtain the concurrence of the OCHAMPUS Medical Director on any decision to grant additional coverage.

The Office of Quality Assurance shall notify the beneficiary, the party acting on behalf of the beneficiary, and the appropriate fiscal intermediary of the decision regarding additional coverage. The Division shall provide the notice by the most expeditious method available. The Division shall also confirm the decision in writing.

CRITERIA FOR REVIEWING REQUESTS FOR MENTAL HEALTH SERVICES IN EXCESS OF 60 DAYS IN A CALENDAR YEAR.

1. INTRODUCTION:

1.1 It is the interpretation of OCHAMPUS that the intent of Congress in enacting the 60 day limitation on acute inpatient mental health services and the waiver provision was to create only a very narrow scope of conditions qualifying for the waiver provision.

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1.2 The criteria below proceed from the general principles governing eligibility for acute inpatient mental health services to describe the very limited clinical situations under which additional days of acute inpatient mental health services might be considered medically/psychologically necessary by peer reviewers and granted by OCHAMPUS.

1.3 Reviewers are cautioned that the intent of the criteria is to support the granting of waivers only in very exceptional cases where the urgency of the need and the prospects for effective outcomes within the requested additional acute inpatient days meet the criteria and are fully supported by the documentation submitted with the request for waiver.

1.4 The limitation on acute inpatient mental health care applies to all inpatient admissions, whether continuous or intermittent, and whether to the same or different institutions. The number of acute * inpatient days paid from different stays * and different institutions are cumulative to the same patient during the calendar year.

* 1.5 Determination of the 60th day when claims are filed out of sequence. *

* a. The 60th chronological day of care will be used in applying the waiver criteria when claims are filed out of sequence by a single provider. This will prevent a provider from manipulating its billing so that the most acute phase of the patient's stay is considered in determining the waiver. The 60th consecutive day can be readily determined from the original admission date on the claim form or from the FI's records. *

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b. When multiple admissions involving more than one provider of care occur during one calendar year, the fiscal intermediary will process claims based upon their date of receipt until 60 days of care have been paid. Claims received reflecting additional care provided prior to or after the 60 days of paid care should be denied and the beneficiary or provider referred to OCHAMPUS for a waiver determination. Each admission is unique and must be evaluated on its own merit.

2. Basis for granting additional days of coverage. In order to be granted coverage of inpatient mental health services in excess of 60 days in a calendar year, the patient's case must meet criteria 2.1 and 2.3 or 2.2 and 2.3.

2.1 Patient is a risk to self or danger to others.

a. Condition is of such severity as to require 24-hour surveillance and services that could not be rendered by partial hospitalization or outpatient services (whether or not such services are available or covered by CHAMPUS).

b. Destabilization has occurred in a patient who is acutely disturbed from severe mental illness, poses an imminent risk to self or a danger to others, and who could not be safely maintained by intensive acute care partial hospitalization services (whether or not such services are available or covered by CHAMPUS). The destabilization is characterized by sudden and severe disruption of significant key supporting mechanisms or relationships; such as death or loss of intimate other, aberrant medication response, sudden and serious intercurrent medical condition.

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2.2 Medical Complications.

a. The medical complications alone are of a nature that require 24-hour acute inpatient services and active medical treatment by qualified medical professionals.

b. The medical complications have significantly contributed to destabilization in a patient who is acutely disturbed from severe mental illness, and who could not be safely maintained by intensive acute care partial hospitalization services if they were available.

c. The medical complications must be treated in the 24-hour acute inpatient setting because the patient's mental illness would prevent recovery from the medical complications and lead to a life threatening or severely exacerbated medical condition.

d. The medical complications experienced are conditions and services otherwise covered under CHAMPUS.

2.3 Services Best Provided In Inpatient Setting.

The services to be provided are of an intensity and nature that are generally recognized as being effectively and safely rendered only in an inpatient setting.

3. DOCUMENTATION.

Documentation submitted with the request for waiver must be adequate to justify the decision of the reviewers in approving a request for waiver.

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3.1 When adequate documentation is not present, reviewers may not assume on the basis of fragmentary documentation that the request is justified.

3.2 Unless the documentation originally submitted with the request adequately supports the waiver criteria, the request for waiver will be denied.

3.3 OCHAMPUS will not request additional information from the providers or the beneficiary to support the request for waiver.

3.4 Guidelines for determining adequacy of documentation include the following:

a. Mental Health Treatment Report (MHTR) and Treatment Summary provide a concise statement of patient condition, progress and factors asserted as qualifying for waiver request. Reviewers are unable to preserve the integrity of the review process if they engage in interpreting the meaning and conclusions of the provider requesting the waiver.

b. Basis for requesting the waiver must be clearly stated with supporting evidence cited from the MHTR and the Treatment Summary.

c. Other documentation submitted must support the conclusions of the Treatment Summary and the MHTR data.

d. Documentation must be legible and readily understood by professional reviewers.

e. The request for waiver must

-Continued-

specify the period of time in excess of 60 days in the calendar year for which additional coverage is requested.

3.5 Documentation submitted must be fully responsive to the specific, narrow scope of conditions qualifying for waiver within the broader context of the principles stated above. Documentation that is responsive only to the general principles is not adequate. It must provide specific definition of:

a. The severity of the patient's conditions.

b. The services/treatment to be rendered.

c. The nature of the danger to the patient or others.

d. The manner in which inpatient care will meet treatment objectives in a way that could not be accomplished in alternative settings.

3.6 The documentation should provide the following information in the treatment plan and chart documentation:

a. Information regarding prior admissions for inpatient care.

b. Principal diagnostic impression and significant associated diagnoses approved by a physician or clinical psychologist using DSM III codes.

c. Treatment plan review and signed approval by physician or psychiatrist, clinical psychologist, and other relevant health care professionals responsible for the treatment of the

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patient, in accord with treatment plan standards and criteria contained therein.

d. Evidence of active direction of the case by a physician or clinical psychologist.

e. Adequate description of current symptomatology and/or behavior (as determined by clinician, case manager, medical director, and utilization review committee) supportive of the diagnosis and need for treatment.

f. Where medical complications are the basis for the request for waiver, the treatment plan and medical records must detail the severity of the medical complications, and the involvement of qualified medical professionals rendering active medical treatment.

g. Treatment plan specific to objectives, milestones, services, treatment duration, and prognosis for the inpatient length of stay preceding request for waiver.

h. Therapeutic objectives, milestones, services (type, frequency, duration), treatment duration, and prognosis (prospective length of stay and discharge date) for the proposed waiver period.

i. Complete drug regimen approved by a licensed physician; or statement that none is used.

j. Daily and other summary progress notes.

k. Record of inpatient treatment, activities and patient's status.

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4. PAYMENT RESPONSIBILITY

4.1 Any inpatient mental health care rendered in excess of 60 days per calendar year is the responsibility of the patient.

4.2 If a request for waiver is filed in accordance with 2.0, above, and the waiver is not granted, CHAMPUS coverage will end as of 12:01 A.M. of the 61st day of inpatient mental health services, regardless of the date of the decision on the request for waiver.

4.3 If the request for waiver is granted, coverage will be provided for the days of inpatient mental health care between the 60th day and the date the decision is made.

Subject: SPECIFIC DEVELOPMENTAL DISORDERS
Chapter: 1
Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.
Page: 12.2.1
Approval: Deputy Director
Date: 5 Dec 84

DESCRIPTION	A specific developmental disorder is a significant impairment in the development of certain skills that is not accounted for by chronological age, mental age, or inadequate schooling. The specific developmental disorders recognized by DSM-III are: developmental reading disorder (also called dyslexia), developmental arithmetic disorder, developmental language disorder (both expressive and receptive), developmental articulation disorder, and mixed specific developmental disorder. These conditions are also referred to as learning disabilities. A condition is not considered a specific developmental disorder if it is a result of or is associated with such conditions as mental retardation, infantile autism or pervasive developmental disorder, visual or hearing impairments, acquired aphasia (normal language followed by onset of language disorder often associated with head trauma, seizures, or EEG abnormalities) or dysarthria (abnormal articulation due to disorders of the oral speech mechanisms or documented neurological abnormalities).
POLICY	Services and supplies, provided in connection with a specific developmental disorder are not covered, with the specific exception of diagnostic and evaluative services required to arrive at a differential diagnosis. Special education of any type is excluded.
EFFECTIVE DATE	November 13, 1984

-Continued-

POLICY CONSIDERATIONS

1. Diagnostic and evaluative services required to arrive at a differential diagnosis are covered when provided by CHAMPUS-authorized providers. Public Law 94-142, the Education for All Handicapped Children Act, requires school districts to make such diagnostic and evaluation services available to all school-age children within the state. CHAMPUS will cover the services only for children younger than school age (age 3 or age 5, depending on the state).

2. Pub. L. 94-142 also requires the states to provide special education and related services (including speech therapy) for children determined to have a learning disability (specific developmental disorder). The states are not required to provide medical treatment.

3. The Regulation excludes coverage for speech therapy for developmental language and articulation disorders.

4. A specific developmental disorder is not a qualifying condition for eligiblity under the Program for the Handicapped.

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Subject: ATTENTION DEFICIT DISORDER	Chapter: 1
	Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.	Page: 12.3.1
Approval Deputy Director	Date: 5 Dec 84

DESCRIPTION	A mental disorder characterized by developmentally inappropriate inattention and impulsivity. Attention deficit disorder is the term used in DSM-III to describe this condition; other terms used include: hyperkinetic reaction of childhood, hyperkinetic syndrome, hyperactive child syndrome, minimal brain damage or dysfunction, minimal cerebral dysfunction, and minor cerebral dysfunction.
POLICY	Otherwise covered services that are medically or psychologically necessary to diagnose or treat attention deficit disorder are covered when provided by CHAMPUS-authorized providers.
EFFECTIVE DATE	November 13, 1984
EXCEPTIONS	Services and supplies related to general or special education are not covered.
POLICY CONSIDERATIONS	1. Because attention deficit disorder is considered a mental disorder, claims will be handled according to the procedures for professional review of other such claims, regardless of the type of provider rendering the care. 2. All claims with a principal diagnosis of attention deficit disorder require second level review to determine the necessity for and appropriateness of the treatment plan.

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Revision No:	Revision Date:

3. In general, the services that would be covered for patients with a diagnosis of attention deficit disorder include:

a. diagnostic testing and assessment, including neurological evaluation.

b. medication.

c. psychotherapy, particularly behavioral therapy and family therapy.

Subject: PSYCHOTHERAPY	Chapter: 1 Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.	Page: 90810.1.1
Approval: Robert D Seaman for Director	Date: December 5, 1984

PROCEDURE CODE RANGE	90810-90811; 90812-90814; 90815-90817; 90818-90820; 90843-90844; 90887; 92870-92871.
POLICY	CHAMPUS benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.
EFFECTIVE DATE	November 13, 1984

POLICY CONSIDERATIONS

1. Maximum duration of psychotherapy sessions:

a. Inpatient or outpatient individual psychotherapy (90843-90844): 60 minutes (usually consists of 50 minutes of actual therapy and 10 minutes of recording session in patient's chart).

b. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes

90810 - group psychotherapy (4-10 persons)

90814 - family psychotherapy - 2 family members

90817 - family psychotherapy - 3 or more family members

90820 - multiple family group

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c. Crisis intervention:

Individual psychotherapy (92870): 120 minutes

Conjoint or family psychotherapy (92871): 180 minutes.

Group therapy involving unrelated members: not applicable.

2. Frequency of psychotherapy sessions.
* Treatment sessions may not be combined, *
* i.e., 30 minutes on one day added to 20 *
* minutes on another day and counted as one *
* session, to allow reimbursement and cir- *
* cumvent the frequency limitation criteria.*

a. Inpatient psychotherapy: more than five sessions per week, of any type of psychotherapy, requires review of the overall treatment plan for necessity and appropriateness.

b. Outpatient psychotherapy: more than two sessions per week, of any type of psychotherapy, requires review of the overall treatment plan for necessity and appropriateness.

c. Multiple sessions the same day: All cases involving more than one psychotherapy session on the same day require professional review of the appropriateness of such therapy. If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy sessions does

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not require review. If review determines that the multiple sessions on the same day were appropriate, up to the full authorized sessions length for each session is payable.

d. Collateral visits (90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy. See the CHAMPUS Policy Manual, Volume I, chapter 1, section 12, page 90887.1.1.

e. Psychoanalysis. Psychoanalysis is payable only after prepayment review by professional reviewers, in accordance with guidelines contained in the "Utilization Review of Mental Health Services," Volume II, Appendix A, Policy Manual.

f. Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit under CHAMPUS, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

g. Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsbile for treatment of the mental disorder is not a

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physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if peer review determines that the patient's condition requires the skills of the multiple providers.

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VOLUME 1

6010.47-M

Subject: PSYCHOTHERAPY	Chapter: 1 Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.	Page: 90841.1.1
Approval: Deputy Director	Date: 5 Dec 84

PROCEDURE CODE RANGE

90841 - 90853

POLICY

CHAMPUS benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

EFFECTIVE DATE

November 13, 1984

POLICY CONSIDERATIONS

1. Duration of psychotherapy sessions:

a. Inpatient or outpatient individual psychotherapy: 60 minutes.

b. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes

c. Crisis intervention:

Individual psychotherapy: 120 minutes

Conjoint or family psychotherapy: 180 minutes.

Group therapy involving unrelated members:
not applicable.

2. Frequency of psychotherapy sessions

a. Inpatient psychotherapy: more than five one-hour sessions per week, of any type of psychotherapy, requires review of the overall treatment plan for necessity and appropriateness.

-Continued-

b. Outpatient psychotherapy: more than two sessions per week, of any type of psychotherapy, requires review of the overall treatment plan for necessity and appropriateness.

c. Multiple sessions the same day: All cases involving more than one psychotherapy session on the same day require professional review of the appropriateness of such therapy. If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review. If review determines that the multiple sessions on the same day were appropriate, up to the full authorized session length for each session is payable.

d. Collateral visits. Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy. See the CHAMPUS Policy Manual, Volume I, chapter 1, section 8, page 90887.1.1.

e. Psychoanalysis. Psychoanalysis is payable only after prepayment review by professional reviewers, in accordance with guidelines contained in the "Utilization Review of Mental Health Services," Volume II, Appendix A, Policy Manual.

-Continued-

f. Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit under CHAMPUS, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

g. Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider rendering psychotherapy is not covered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of the same or different disciplines is covered only if peer review determines that the patient's condition requires the skills of the mulitple providers.

Subject: CHEMOTHERAPY MANAGEMENT	Chapter: 1 Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.	Page: 90862.1.1
Approval: Deputy Director	Date: 5 Dec 84

PROCEDURE CODE	90862
DESCRIPTION	Professional services of a physician provided in connection with psychotropic drugs, including prescription, use, and review of medication with no more than minimal psychotherapy.
POLICY	Chemotherapy management is covered only as an independent procedure. If the provider is also providing psychotherapy, services provided in connection with chemotherapy management are included in the allowable charge for the psychotherapy. A separate charge for chemotherapy management is not payable.
EFFECTIVE DATE	November 13, 1984
POLICY CONSIDERATIONS	Charges for chemotherapy management are not covered if the provider billing for such services is not qualified by state licensure to prescribe psychotropic drugs. The allowable charge for chemotherapy management may not exceed the prevailing charge for an office or hospital visit, according to the setting in which the patient is being treated.

Revision No:

Revision Date:

Subject: COLLATERAL VISITS	Chapter: 1 Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.3.i.	Page: 90887.1.1
Approval Deputy Director	Date: December 5, 1984

PROCEDURE CODE 90887

DESCRIPTION Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

POLICY Collateral visits that are medically or psychologically necessary for the treatment of the patient are covered.

EFFECTIVE DATE October 1, 1980.

POLICY CONSIDERATIONS A collateral visit does not involve treatment of the collateral person(s). It is for purposes of information exchange regarding the patient or implementing treatment goals for the patient. Collateral visits are considered as services rendered on behalf of the patient, are billed in the name of the patient, and are counted as individual psychotherapy sessions for purposes of utilization review (See Policy Manual, Volume I, chapter 1, section 12, 90801.1.1). Duration up to 60 minutes is allowed.

* Group collateral visits are not covered. *
* A group collateral visit is where the *
* therapist meets with a group of parents *
* of the children he/she sees in group *
* therapy. The focus of the sessions is on *
* improving parenting techniques and *
* fostering better implementation goals. *
* Such visits shall be denied. *

-Continued-

Revision No: 1 Revision Date: May 21, 1985

Subject: COLLATERAL VISITS

Chapter: 1 Section: 12 Page: 90887.1.2

A collateral visit rendered on the same day that the patient receives individual or group psychotherapy is coverable.
* Collateral visits do not count toward crisis intervention sessions. *

Development of the claim is only required if there is some reason for the FI to suspect that it is not truly a collateral visit. When routine treatment reports are submitted, collateral visits should be explained therein.

Pre-payment development is not required. If there is some reason to suspect that the collateral person is actually receiving treatment, the records should be requested and the case sent to peer review.

Subject: BIOFEEDBACK	Chapter: 1
*	Section: 13 *
Authority: DoD 6010.8-R, Chapter IV.G.63	Page: 90900.1.1
Approval: Keith W Curtis Deputy Director	Date: January 23, 1984

PROCEDURE CODE RANGE 90900 - 90915

POLICY

All biofeedback procedures are excluded including relaxation therapies such as Electro-Sleep and Cerebral Electrotherapy. EMG Feedback, Temperature Differential Feedback, and EEG Feedback are also excluded even if these procedures are part of a psychotherapeutic program.

Subject: GASTROENTEROLOGY	Chapter: 1
	* Section: 15 *
Authority: DoD 6010.8-R, Chapter VI, B.2.g.	Page: 91000.1.1
Approval: Keith W Carter	Date: APR 19 1983

PROCEDURE CODE RANGE 91000 - 91299

DESCRIPTION

Gastroenterological services are those non-surgical procedures performed to diagnose conditions of the gastrointestinal system.

POLICY

Gastroenterological services are covered when performed by individual professional providers, or by the staff of institutional providers, and medically necessary for the diagnosis of a covered condition.

Revision No:	Revision Date:

Ch 22, October 15, 1984

Subject: EYE EXAMINATIONS - BASIC PROGRAM	Chapter: 1 Section: 16
Authority: DoD 6010.8-R, Chapter IV.G.51	Page: 92002.1.1
Approval: Deputy Director	Date: January 23, 1984

PROCEDURE CODE RANGE: 92002 - 92014

POLICY

1. A routine eye examination is the examination and diagnostic services which are customarily rendered in an eye examination, including but not limited to procedures used for eye health evaluation and determination of functional vision. The routine examination may include:

   a. A comprehensive examination of both the internal and external structures of the eye to detect eye disease and signs of systemic disease;

   b. Subjective and objective tests to evaluate the patient's functional vision; and

   c. Analysis of findings and diagnosis.

2. Beginning with services rendered on or after October 1, 1984, CHAMPUS will cover one routine eye examination per calendar year per person for dependents of active duty personnel only. (See COM-FI, Part 2, Chapter 1, pages 1-90.2 and 1-165, and Part 3, Chapter 4, page 4-126.12.)

3. Routine eye examinations for beneficiaries other than dependents of active duty members are not covered. However, CHAMPUS will still cover eye examinations for all eligible beneficiaries, if the examination is related to a covered condition, such as cataracts, and is for other than a refraction.

Subject: ORTHOKERATOLOGY	Chapter: 1 *Section: 16*
Authority: DOD 6010.8-R, Chapter IV, E.6. & G.49.,50.,53.	Page: 92499.1.1
Approval: Keith W Curtis	Date: NOV 01 1983

PROCEDURE CODE	92499
DESCRIPTION	Orthokeratology is the reduction, modification or elimination of refractive errors by the programmed application of contact lenses or other related procedures. In the same sense that teeth may be straightened by the use of dentistry, it is the objective of orthokeratology to reduce or eliminate, by the use of specially designed contact lenses, refractive errors, i.e., irregularities of the eye. The technique is long term, usually applied over a two year time span. Orthokeratology is usually performed by optometrists. The procedure is done on pathology-free eyes, i.e., eyes which are correctible to standard visual acuity from ordinary refractive errors.
POLICY	Orthokeratology is not a benefit of CHAMPUS, regardless of the circumstances under which it is performed.
POLICY CONSIDERATIONS	Since this modality is essentially a method to ultimately avoid wearing glasses, CHAMPUS would not cover the glasses either.

Subject: TINNITUS MASKER	Chapter: 1
	* Section: 17 *
Authority: DoD 6010.8-R, Chapter IV, G. 15	* Page: 17.1.1 *
Approval: Keith W Carter	Date: NOV 01 1983

DESCRIPTION

Tinnitus is the perception of noise in the ear or head area. A tinnitus masker is a device worn behind the ear by persons seeking relief from tinnitus. The masker produces sounds a few decibels above the person's audible threshold, providing distraction from the tinnitus. There are two types of maskers--one that introduces stimulus acoustically and the other, electrically. This distraction is intended to alleviate the discomfort and debilitation associated with sound within the ear or head area.

POLICY

Tinnitus maskers are not covered because they are considered experimental or investigational due to a lack of controlled clinical trials. There is the possibility that use of the device over a prolonged period of time may cause further hearing deterioration.

Revision: -- Revision Date: --

Subject: OTORHINOLARYNGOLOGIC SERVICES	Chapter: 1
	* Section: 17 *
Authority: DoD 6010.8-R, Chapter IV, G.50. and Chapter V, H.2.a.	Page: 92502.1.1
Approval: Keith W Curtis	Date: APR 19 1983

PROCEDURE CODE RANGE 92502 - 92599

DESCRIPTION

Otorhinolaryngology is that branch of medicine concerned with medical and surgical treatment of the head and neck, including the ears, nose and throat.

POLICY

Otorhinolaryngological services, including audiological services, are covered only when necessary for the diagnosis or treatment of a covered medical condition.

EXCEPTIONS

Audiological services are not covered under the Basic Program unless they are related to the diagnosis or treatment of a medical or surgical condition or as outlined below. Examination to determine the need for hearing aids are not covered, except under the Program for the Handicapped.

Audiological services to determine the extent of a hearing loss for qualifying for speech therapy benefits, as outlined * in Section 17, page 92507.1.2 of this * Chapter 1, are also covered.

POLICY CONSIDERATIONS

1. Audiological services must be prescribed by a physician.

2. Audiological services are payable without preauthorization if the beneficiary is subsequently determined to be eligible for the Program for the Handicapped.

Subject: SPEECH THERAPY - BASIC PROGRAM	Chapter: 1
	Section: 17
Authority: DoD 6010.8-R, Chapter IV, G.46.	Page: 92507.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE 92507 - 92508

DESCRIPTION

The use of special techniques for correcting speech and language disorders.

POLICY

Speech therapy is specifically excluded under the provisions of DoD 6010.8-R except when prescribed by a physician and rendered as a part of active treatment addressed to the physical defect itself and not to any educational or occupational deficit. Payment may only be made for those conditions identified under Policy Considerations below and when the therapy is rendered by a CHAMPUS-authorized speech therapist.

POLICY CONSIDERATIONS

1. Covered conditions. Payment for speech therapy is limited to active treatment of the physical defects listed below.

a. Following a cerebrovascular accident (includes subarachnoid hemorrhage, cerebral hemorrhage and cerebral aneurysm).

b. Post-craniotomy for abscess, intracranial hemorrhage or tumor; post-head injuries; post-comatose conditions or post-meningitis, encephalitis or brain abscess; post-hydrocephalus for the sequelae or residual of previous damage that is documented as stable and under adequate control.

c. For congenital anomalies, such as cleft lip and cleft palate.

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d. For a hearing loss. Hearing loss is defined as a loss greater than 25 decibels of the pure tone average of intensities at 500, 1000 and 2000 hertz. Includes developmental hearing loss, acquired hearing loss and hearing loss resulting from documented chronic otitis media.

(1) Developmental hearing loss is decreased hearing sensitivity with onset before language is fully developed.

(2) Acquired hearing loss is that decreased hearing sensitivity with onset after language is fully developed.

(3) Hearing loss resulting from chronic otitis media. Therapy for this condition is covered if the occurrence of otitis media has been frequent enough during the formative years of speech to produce a delay in either speech or language. The otitis media must be supported by medical documentation.

e. Resulting from a therapeutic process, such as vocal cord surgery, laryngectomy or radiation therapy.

f. For vocal cord nodules, either in lieu of surgery, or as pre-operative treatment.

g. Cerebral palsy.

2. Exclusions. Speech therapy is not covered when the speech problem is the result of or complicated by the following conditions:

a. Psychosocial speech delay (includes delayed language development).

b. Syndromes associated with diagnosed disorders attributed to perceptual and

-Continued-

conceptual dysfunctions (with the exception of hearing loss as contained in paragraph 1.d., above).

c. Mental retardation; Down's syndrome.

d. Attention deficit disorders. Includes associated behavior problems, including impulsivity behavior; hyperkinetic and hypokinetic disorders; and minimal brain dysfunction.

e. Educational or occupational deficits to include learning disabilities and dyslexia.

f. Lisping or stuttering.

g. Bronchitis or laryngitis.

* h. Developmental articulation disorders (DSM III 315.39) and developmental language disorders, expressive and receptive types (DSM III 315.31). *

i. Spina bifida.

j. Myelomeningocele.

k. Infantile autism.

l. Paraplegia; quadriplegia.

m. Myofunctional or tongue thrust therapy.

n. Any other condition not specifically addressed herein is also excluded.

3. Esophageal speech training. Esophageal speech training is covered when the patient has had vocal cord surgery (laryngectomy) or radiation treatment.

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4. Length of individual speech therapy sessions.

a. Patients five years of age and under: 30 minutes per individual speech therapy session is generally considered medically appropriate.

b. Patients over five years of age: one hour per individual speech therapy session is generally considered medically appropriate.

5. Group speech therapy. CHAMPUS payment may be made for group therapy when, in the opinion of the attending or referring physician and the speech therapist, the patient would derive significant benefit from the group therapy. Group speech therapy sessions should generally be no longer than 90 minutes in duration.

6. Claims review.

a. Number of sessions. Speech therapy which extends beyond 30 individual or group (or a combination of individual and group) sessions per year must be justified with a report from the speech therapist which documents the goals of treatment and which establishes that the patient is making reasonable progress toward those goals. Such claims must be submitted to medical review for a determination that the treatment goals are reasonable and that the patient can reasonably be expected to achieve those goals. Progress from speech therapy should be measured in terms of the patient's improvement in relation to the specific treatment goals set at the outset of therapy. Documentation of improvement must include formal record keeping, formal

-Continued-

testing and formal graphing (including base rate and percentage of increase or decrease).

b. Length of sessions. Speech therapy which exceeds the customary length as indicated in paragraph 4 above must be justified with a report from the speech therapist.

c. Furnished by local, state, or other federal agency. CHAMPUS benefits are not payable for speech therapy provided to any child who is eligible to receive such services through the public school system. Claims for speech therapy for beneficiaries under the age of 19 must document the reason that the services are not being funded under the provisions of Public Law 94-142, the Education for All Handicapped Children Act. Any claim eligible for payment by a state (except for Medicaid) or other federal agency must be denied.

d. Requests for additional documentation. Additional documentation must be obtained by the fiscal intermediary in any case where a determination cannot otherwise be made as to the reasonableness of the treatment program. Failure to provide sufficient documentation will result in denial of the claim.

Subject: AUDIOLOGICAL SERVICES	Chapter: 1 * Section: 17 *
Authority: DoD 6010.8-R, Chapter IV, G.50. and V, C. and E.2.c.	Page: 92551.1.1
Approval:	Date: APR 19 1983

PROCEDURE CODE RANGE

92551 - 92596

DESCRIPTION

Treatment for impaired hearing that cannot be improved by medication or surgical therapy.

POLICY

Basic Program - Audiological services are covered only when necessary for the diagnosis of a medical or surgical condition and as outlined in Section 15, page 92502.1.1 of this Chapter 1.

Program for the Handicapped - Audiological services are covered when provided to a beneficiary determined to be eligible for benefits under the Program for the Handicapped on the basis of a hearing impairment or of multiple handicaps, one of which involves a hearing handicap.

POLICY CONSIDERATIONS

1. Audiological services must be prescribed by a physician.

2. Audiological services may be paid without preauthorization if the beneficiary is subsequently determined to be eligible for the Program for the Handicapped.

Revision No:	Revision Date:

Subject: HEARING AID SERVICES	Chapter: 1 *Section: 17 *
Authority: DoD 6010.8-R, Chapter IV, G.54. and V, E.2.c.	Page: 92590.1.1
Approval:	Date: APR 19 1983

PROCEDURE CODE RANGE	92590 - 92596
POLICY	Hearing aid services are covered only for beneficiaries eligible for the Program for the Handicapped on the basis of a hearing impairment or of multiple handicaps, one of which involves a hearing handicap.

Revision No: Revision Date:

Subject: CARDIAC REHABILITATION PROGRAMS	Chapter: 1
	* Section: 18
Authority: DoD 6010.8-R, Chapter IV, G. 43 and G. 45.	Page: 93797.1.1
Approval: Deputy Director	Date: November 1, 1983

PROCEDURE CODE 93797

POLICY

Cardiac Rehabilitation Programs are not covered by CHAMPUS. There is no extension of benefits for the monitoring of any tests while participating in these programs since the tests provided are related to a non-covered episode of care and are not performed for either a diagnostic or treatment purpose.

NOTE: Procedure code 93797, although not listed in CPT-4, is being used for cardiac rehabilitation programs in order that specific data can be retrieved for
* statistical purposes (see COM-FI, Part *
* 3, Chapter 4, Addendum J, Table 7.) *

Subject: PULMONARY SERVICES	Chapter: 1
	* Section: 20 *
Authority: DoD 6010.8-R, Chapter IV, B.2.r. and C.3.n.	Page: 94010.1.1
Approval: Keith W Carter	Date: APR 19 1983

PROCEDURE CODE RANGE	94010 - 94799
DESCRIPTION	Services provided for the diagnosis or treatment of conditions involving the lungs.
POLICY	Pulmonary services are covered when provided by a CHAMPUS-authorized provider for the diagnosis or treatment of a ~~specific~~ medical condition or set of symptoms.
EXCEPTIONS	Pulmonary services provided as part of a program of cardio-pulmonary rehabilitation are not covered.
POLICY CONSIDERATIONS	Respiratory therapists are not authorized individual providers under CHAMPUS. Services provided by respiratory therapists are covered only when the therapist is an employee of a CHAMPUS-authorized institutional provider.

Revision No: Revision Date:

Subject: ALLERGY TESTING AND TREATMENT	Chapter: 1 Section: 21
Authority: DoD 6010.8-R, Chapter IV, C.2.m.	Page: 95000.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE	95000 - 95199
DESCRIPTION	The testing and treatment of conditions related to allergies.
POLICY	Allergy testing and treatment are covered.
EXCEPTIONS	1. The following allergy testing procedures are considered investigational and are not covered: Leucocyte histamine release. Intracutaneous (intradermal) and subcutaneous provocative and neutralization testing for food allergies. * Cytotoxic leukocyte test for food and inhalant allergies. Sublingual provocative testing for food and inhalant allergy. Rebuck skin window test. Passive transfer (Prausnitz-Kustner) test. Rinkel method and all other types of skin-test end point titration. 2. The following allergy treatment procedures are considered investigational and are not covered: Sublingual antigen therapy.

* (margin change mark beside "testing for food allergies.")

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Sublingual neutralization therapy for food and inhalant allergy.

Urine autoinjection (autogenous urine immunization).

* Intracutaneous (intradermal) and subcutaneous neutralization therapy for food allergies. *

Injections of antigens based on Rinkel method of immunotherapy or other type of skin-test end point titrations.

POLICY CONSIDERATIONS

1. Claims exceeding the guidelines below must be justified in writing and must be submitted to medical review to determine medical necessity and appropriateness. More frequent review and evaluation may be required if indicated by the case. Claims should be denied at the point at which medical necessity no longer exists.

a. Epicutaneous skin tests, e.g., scratch, prick, puncture which exceed 100 tests.

b. Intradermal skin testing which exceeds 75 tests.

c. Intradermal testing for delayed hypersensitivity of the tuberculin type which exceeds 8 tests.

d. Patch testing which exceeds 30 tests.

e. RAST (Radio Allergosorbent Test). All claims for RAST require medical review. Payment may be made only when one of the following circumstances is documented:

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(1) direct skin testing is impossible because the patient has extensive dermatitis or marked dermographism;

(2) direct skin testing is impossible because the patient is four years of age or younger; or

(3) direct skin testing is inconclusive and a further diagnostic test is necessary.

f. Total serum IgE Concentration. This test is not indicated for all allergic patients; it should be reserved for those with such conditions as severe eczema, hypersensitivity lung disease or allergic bronchopulmonary aspergillosis. Medical review is required for all claims.

g. Bronchial challenge testing. All claims for this procedure require medical review: Payment may be made when the test is necessary for the difficult asthmatic patient for whom routine skin testing is not sufficient to determine which allergic factors are responsible for the asthma.

h. Nasal challenge testing. This test is not required for the routine testing of allergic patients. All claims for this procedure, which involves the precise measurement of changes in the resistance of the nasal airways, require medical review. The "sniff test," in which a direct visual assessment is made of the nasal mucosa after inhaling pollen, is not covered.

i. Conjunctival challenge testing. This test is not required routinely. All claims require medical review.

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j. Food challenge testing. Food challenge testing done as an office procedure must be justified by report and must be submitted to medical review. Food challenge testing is covered only to diagnose food allergies. It is not covered when used in the diagnosis of such conditions as rheumatoid arthritis, depression, or respiratory disorders. Food challenge testing performed in connection with clinical ecology programs not covered.

2. All claims for allergy testing must indicate the type and number of tests performed.

3. The following guidelines apply to payment of claims for allergy treatment (desensitization or immunotherapy):

a. All payment for antigen sets is to be made on a reasonable charge basis.

b. Three antigen sets (concentrated treatment antigen plus its serial dilutions) may be allowed initially without review.

c. Within the first year, one replacement set if the initial three antigen sets are covered.

d. In the second and subsequent years, replacement of a maximum of three antigen sets is covered.

e. Up to 64 allergy injection treatments may be payable in the first year. In the second and subsequent years, up to 52 allergy injection treatments per year may be payable. Services in excess of these limits require written justification by report and must be submitted to medical review for determination of the medical necessity.

Subject: NEUROLOGY AND NEUROMUSCULAR SERVICES
Chapter: 1
* Section: 22 *
Authority: DoD 6010.8-R, Chapter IV, B.2.g. and B.3.e.
Page: 95819.1.1
Approval: Keith W Curtis
Date: APR 19 1983

PROCEDURE CODE RANGE	95819 - 95937
DESCRIPTION	The diagnosis and treatment of muscle and nerve disorders.
POLICY	These procedures are covered when rendered by authorized professional providers for the diagnosis or treatment of a specific illness, condition or set of symptoms.

Revision No: Revision Date:

Subject: HOME PHOTOTHERAPY	Chapter: 1 Section: 24
Authority: DoD 6010.8-R, Chapter IV.G.15	Page: 24.1.1
Approval: Deputy Director	Date: 12 Oct 94

DESCRIPTION	Phototherapy administered at home for infants with physiologic jaundice. Equipment for the home phototherapy generally includes a fluorescent phototherapy lamp, eye shields, rectal thermometer, and a room thermometer.
POLICY	Home phototherapy is not covered. There are concerns about the safety of this home-centered care and questions on the necessity for treating mild physiologic jaundice. Standards for initiation or discontinuance of phototherapy have not been established.

Revision No: Revision Date:

Subject: DERMATOLOGICAL PROCEDURES - GENERAL	Chapter: 1 * Section: 24 *
Authority: DoD 6010.8-R, Chapter IV, C.2.n.	Page: 96900.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE	96900 - 96999
DESCRIPTION	The diagnosis and treatment of skin disorders.
POLICY	Unless otherwise limited or excluded by this Policy Manual, dermatological services are covered when provided by a CHAMPUS-authorized provider for the treatment of a covered condition.
POLICY CONSIDERATIONS	1. Medically appropriate treatment for acne is covered. 2. For coverage of PUVA, see page 96910.1.1 of this Section. 3. Dermabrasion is not covered under CHAMPUS. See Chapter 3, Section 2, page 15780.1.1. 4. Collagen implantation is not a benefit under CHAMPUS. See Chapter 3, Section 2, page 11950.1.1.

Subject: PHOTOCHEMOTHERAPY FOR PSORIASIS

Chapter: 1

Section: 24

Authority: DoD 6010.8-R, Chapter IV, D.3.f

Page: 96910.1.1

Approval:

Date: Dec 29, 1982

PROCEDURE CODE RANGE	96910 - 96912
DESCRIPTION	Photochemotherapy using coal tar products and ultraviolet B light is called the Goeckerman treatment. Photochemotherapy using the drug, methoxsalen, and ultraviolet A light is called PUVA.
POLICY	Both the Goeckerman treatment and PUVA are covered when used in the treatment of psoriasis.
EFFECTIVE DATE	Goeckerman treatment (See date above.) PUVA - May 7, 1982.
POLICY CONSIDERATIONS	PUVA is covered only for the treatment of severe, disabling psoriasis which is refractory to treatment by other means, including the Goeckerman treatment. Questionable cases should be referred to medical review to determine the appropriateness of PUVA given the potential long-term risks, such as skin cancer and premature aging of the skin.

Revision No: Revision Date:

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Subject: PHYSICAL THERAPY	Chapter: 1 * Section: 25 *
Authority: DoD 6010.8-R, Chapter IV, B.2.k., B.3.g., C.3.j.	Page: 97010.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE 97010 - 97799

DESCRIPTION

The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of a body part.

Physical therapy services consists of the physical evaluation of a patient by muscle testing and other means, and the prescribed therapeutic treatment and services of a definite functional nature prescribed by a physician and professionally administered by a registered physical therapist to aid in the recovery from disease or injury, to help the patient in attaining greater self-sufficiency, mobility and productivity through exercises and other modalities intended to improve muscle strength, joint motion, coordination and endurance.

POLICY

CHAMPUS benefits are payable for inpatient or outpatient physical therapy services which are medically necessary for the treatment of a covered condition and which meet all the following criteria:

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1. The services must be provided by a physician or, upon a physician's order and under a physician's general supervision, by a licensed, registered physical therapist.

2. The services must be directly and specifically related to an active written treatment regimen designed by the physician and the physical therapist.

3. The services must be of such a level of complexity and sophistication, and the condition of the patient must be such that the judgement and knowledge of a physician and the skills of a licensed, registered physical therapist are required.

4. There must be a reasonable expectation, based on the assessment made by the physician and the physical therapist, that the service will produce significant improvement in the patient's condition in a reasonable and generally predictable period of time, or that the services are necessary to the establishment of a safe and effective maintenance program required in connection with a specific medical condition.

The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's medical condition.

EXCEPTIONS

The following services are not covered:

Diathermy, ultrasound, and heat treatments for pulmonary conditions.

-Continued-

Diapulse.

General exercise programs, even if recommended by a physician and rendered by a physical therapist.

Electrical nerve stimulation used in the treatment of upper motor neuron disorders such as multiple sclerosis.

Separate charges for instruction of the patient and family in therapy procedures.

Repetitive exercise to improve gait, maintain strength and endurance, and assistative walking such as that provided in support of feeble or unstable patients.

Range of motion and passive exercises which are not related to restoration of a specific loss of function, but are useful in maintaining range of motion in paralyzed extremities.

Maintenance physical therapy after a therapy program has been designed by a licensed physical therapist.

Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

POLICY CONSIDERATIONS

1. The following specific physical therapy services are covered:

Evaluation procedures, including testing of joint range of motion and mobility, skeletal muscle strength, posture and gait, limb length and circumference, activities of daily living,

-Continued-

pulmonary function, sensation and sensory perception, reflexes and muscle tone, sensorimotor and other skilled performance.

Massage, cold packs, ice, ice massage, hydrotherapy, hot pack, hydrocollator, infra-red treatments, and paraffin, when the condition of the patient is such that the skills of physical therapist are required or when provided as a prerequisite to skilled physical therapy.

Therapeutic massage, when included as part of an overall physical therapy treatment plan.

Ultrasound, shortwave, microwave diathermy, ultraviolet, traction, transcutaneous nerve stimulation, iontophoresis and alternate vascular compressor.

Mobility evaluation and training, when included as part of an overall physical therapy treatment plan and when there is a reasonable expectation that the patient's ability to ambulate or motate will improve.

Therapeutic exercises which require the skills of a licensed physical therapist.

Range of motion tests are covered. Range of motion exercises require the skills of a physical therapist only when they are a part of the active treatment of a specific condition which has resulted in loss or restriction of mobility.

Postural drainage, vibration and cupping, breathing exercises, intermittent positive pressure breathing treatments and chest wall mobilization, when provided in the treatment of chronic respiratory diseases.

-Continued-

2. Providers are to be encouraged to submit claims monthly for on-going physical therapy services.

3. Information required on claims:

Physician's certification of treatment plan. The initial claim must include a statement from the referring physician which contains: the diagnosed condition and related functional impairment(s) for which therapy is prescribed; the date of onset of the impairment, if known; the type of therapy, frequency of therapy and estimated length of time therapy will be required, goals of treatment.

Recertification by the physician is not required unless medical review has a question regarding the reasonableness of therapy or there is a change in the treatment plan which extends the length of time previously determined to be necessary.

The physical therapist must submit an evaluation report with each claim which documents the patient's progress during the period since the last claim. There must be documentation of a reasonable degree of progress or the claim must be denied. Questionable cases should be referred to medical review to determine whether the patient is benefiting sufficiently from therapy to warrant continuation of the services.

All claims must indicate the specific modalaties or procedures performed.

4. Frequency of physical therapy.

Two physical therapy sessions per week are generally considered sufficient for most conditions. Claims for greater

-Continued-

frequency may be payable if the physician's certification documents the medical necessity for the frequency on the basis of the patient's condition. Medical review is required for questionable cases.

5. Duration of physical therapy.

Most physical therapy cases should be completed within 60 days. In any case where physical therapy continues to be payable for up to 60 days, medical review is required to determine the medical necessity for additional care. CHAMPUS benefits cannot be extended beyond the point where the patient can reasonably be expected to benefit significantly from continued physical therapy.

6. Condition and problem sets.

The following sets of conditions and associated problems will be used for screening claims. When a claim is received for one of the conditions listed, the initial physician's certification should contain evidence of one or more of the problems in the corresponding list. (The problems can be associated with any of the conditions related to a specific dysfunction.) If a claim is received for a condition or a problem not listed, the claim should be submitted to medical review for an assessment of the necessity for physical therapy. Claims or initial physician's certifications which contain documentation of one or more of the listed problems or conditions must also meet all other coverage requirements in order to be paid.

-Continued-

DYSFUNCTION: SPINAL COLUMN CONDITIONS

Conditions

Compression fracture
Degenerative osteoarthritis
Flexion-extension injury
Fusion
Herniated nucleus pulposus
Kyphosis
Lordosis
Nerve root compression
Nerve root irritation
Osteoporosis
Paraplegia
Post laminectomy
Quadriplegia
Radiculitis
Radiculopathy
Ruptured or prolapsed disc
Sciatica
Spina bifida
Spondylolisthesis
Spondylosis
Strain or sprain
Subluxation
Torticollis
Whiplash

Associated Problems

Abnormal gait pattern
Degenerative disc disease
Guarding
Headaches
Hypermobility or hypomobility of joints
Improper posture and/or body mechanics
Inadequate chest excursion
Lack of functional range of motion, strength and/or motor control
Lack of mobility skills for activities of daily living (ADL), transfers and gait.
Lack or, decreased, or changes in sensation
Muscle spasm

-Continued-

Muscular imbalance
Need of equipment and/or adaptive devices
Pain
Paralysis
Presence of trigger points
Weakness

DYSFUNCTION: MUSCULOSKELETAL CONDITIONS

Conditions

Acromioclavicular separation
Adhesive capsulitis
Arthrogryposis multiplex congentia
Bone graft
Bursitis
Chondromalacia
Crush injuries
Dupuytren's contracture
Fractures
Frozen shoulder
Hemiarthrosis
Internal derangement
Mechanical low pack pain including that associated with pregnancy
Post-dislocation
Post-fractures
Rotator cuff tear
Ruptured ligaments, tendons, muscles
Shoulder-hand syndrome
Slipped epiphysis
Strain or sprain
Synovitis
Tendonitis

Associated Problems

Abnormal gait pattern
Contractures
Disuse atrophy - deconditioning
Joint instability
Lack of functional range of motion (ROM) and/or strength
Lack of joint play

-Continued-

Muscle guarding/spasm
Muscular wasting
Need for muscle re-education
Pain

DYSFUNCTION: POST-SURGICAL CONDITIONS

Conditions

Amputation
Arthrodesis
Athrotomy
Bunionectomy
Cardiac surgery
Disarticulation
Hip prosthesis
Joint fusion
Joint manipulation
Ligament and tendon repairs
Mastectomy
Open reduction--internal fixation
Patellectomy
Tendon transfer
Thoracotomy
Total ankle arthroplasty
Total hip arthroplasty
Total knee arthroplasty
Total shoulder arthroplasty
First rib resection

Associated Problems

Abnormal gait pattern
Contractures
Decreased endurance
General deconditioned state
Improper posture and or body mechanics
Inability or incapability of preserving functional ROM and/or strength
Lack of mobility skills for ADL, transfers, gait
Muscle guarding/spasm
Need for equipment and/or adaptive devices
Need for muscle re-education

-Continued-

Need for pre/post prosthetic training
Pain
Stump and skin care

DYSFUNCTION: RESPIRATORY DISTURBANCES

Conditions

Asthma
Bronchiectasis
Bronchitis
Chronic obstructive pulmonary disease
Cor pulmonale
Cystic fibrosis
Emphysema
Empyema
Lung infection
Middle lobe syndrome
Plural effusion
Pneumonia
Respiratory failure
Tuberculosis

Associated Problems

Decreased endurance
Establish and review home program
General deconditioned state
Inability to mobilize secretions
Inadequate breathing pattern
Inadequate chest excursion
Lack of skill to cope with shortness of breath
Poor cough
Shortness of breath with ADL

DYSFUNCTION: DECONDITIONED-DETERIORATED STATES

Conditions

Alcoholism
Cancer
Neurological and cutaneous complication of diabetes mellitus

-Continued-

Organ transplant
Renal failure

Associated Problems

Decreased endurance
General deconditioned state
Lack of functiona ROM, strength and/or motor control
Lack of mobility skills for ADL, transfer, gait
Muscle alienation
Pain

DYSFUNCTION: ARTHRITIS AND RHEUMATISM

Conditions

Acute arthritis or polyarthritis due to infection
Ankylosing spondylitis
Degenerative arthritis
Degenerative joint disease
Dermatomyositis
Juvenile rheumatiod arthritis
Osteoarthritis
Polymyositis
Rhematiod arthritis
Sceroderma
Synovitis
Systemic lupul erythematosus
Traumatic arthritis

Associated Problems

Abnormal gait pattern
Breathing difficulties secondary to deformities
Contractures
Decreased endurance
General deconditioned state
Improper posture and/or body mechanics
Inability to or incapability of preserving ROM and/or strength

-Continued-

Lack of functional ROM, strength, and or motor control
Lack of knowledge of joint preservation
Lack of mobility skills for ADL, transfers, or gait
Muscle guarding/spasm
Need for equipment and/or adaptive devices
Pain
Presence of inflammatory process
Stress control - joint protection

DYSFUNCTION: VASCULAR DISEASE

Conditions

Duerger's disease
Cellulitis
Congestive heart failure
Gangrene
Intermittent claudications
Lymphedema
Myocardial infarction
Peripheral vascular disease
Phlebitis
Transient ischemic attacks
Varicose veins
Venous ulcers

Associated Problems

Decreased endurance
Edema
General deconditioned state
Pain
Presence in inflammatory process
Slow wound healing
Wound infection

-Continued-

DYSFUNCTION: PERIPHERAL NERVE

Conditions

Amyotrophic lateral sclerosis
Bell's palsy
Carpal tunnel syndrome
Erb's palsy
Gullain-Barre syndrome
Herpes zoster
Klumpke's gravis
Myasthenia gravis
Neuralgia
Neuritis
Peropheral nerve injury
Peripheral neuropathy
Polio
Polyneuritis
Polyradiculitis
Reflex sympathetic dystrophy
Stretch palsies
Thoracic outlet syndrome

Associated Problems

Decreased coordination
General deconditioned state
Improper posture and or body mechanics
Change or decrease in sensation
Lack of functional ROM, strength and/or motor control for ADL
Lack of mobility skills
Muscle alienation
Muscle guarding/spasm
Need for equipment or adaptive devices
Need for muscle re-education
Pain

DYSFUNCTION: NERVOUS SYSTEM

Conditions

Brain tumor
Cerebral arterial sclerosis

-Continued-

Cerebral atrophy
Cerebral palsy
Comatose/semi-comatose
Concussion
CVA (stroke, hemiparesis)
Encephalitis
Hydrocephalus
Meningitis
Mental redardation
Multiple sclerosis
Paralysis agitans
Parkinsonism
Subdural hematoma

Associated problems

Spasticity, flaccidity
Hypertonicity, hypotonicity, fluctuating tone, rigidity, athetosis
Absense of righting reaction or equilbibrium response
Ataxia
Contractures
Decubitis ulcers
Developmental sequence
Disturbances of perception, sensation or proprioception
Edema
Impaired balance
Lack of cognitive function (level of awareness)
Lack of functional ROM, strength or motor control for ADL
Lack of mobility skills
Muscle imbalance
Need for equipment or adaptive devices
Poor coordination
Presence of primitive or pathological reflexes

-Continued-

DYSFUNCTION: SKIN

Conditions

Burns
Decubitus ulcers
Open wounds
Psoriasis
Soft tissue ulceration

Associated Problems

Contractures
General deconditioned state
Improper posture or body mechanics
Inability or incapability of preserving ROM or strength
Lack of functional ROM, strenght or motor control for ADL, transfers, or gait
Lack of mobility skills
Need for wound cleaning, debridement, or dressing
Pain
Presence of active inflammatory process
Slow wound healing
Splinting
Wound infection

Subject: OSTEOPATHIC MANIPULATIVE THERAPY	Chapter: 1
	* Section: 25 *
Authority: DoD 6010.8-R, Chapter IV, C.2.d.	* Page: 25.2.1 *
Approval: Keith W Curtis	Date: April 19, 1983

PROCEDURE CODE RANGE	97660 - 97664 (see Part 3, Chapter 4, Addendum J, COM-FI, for corresponding American Osteopathic Association codes).
DESCRIPTION	Treatment of ailments by manipulation to detect and correct faulty structure based in part on the theory that the human body is capable of making its own remedies if its physical and physiological integrity is intact.
POLICY	Osteopathic manipulative therapy is covered under CHAMPUS when determined to meet the CHAMPUS appropriate medical care concept. The physical therapy limitations outlined in the Regulation should not be applied to osteopathic manipulation. Medical necessity must be determined on a case-by-case basis. The osteopathic manipulative therapy must be provided by or under the direct supervision of a Doctor of Osteopathy, and standard diagnostic language (such as in the ICD-9) must be used.

Revision No: 1 Revision Date: NOV 01 [illegible]

Subject: NUTRITION THERAPIES	Chapter: 1
	* Section: 26 *
Authority: DoD 6010.8-R, Chapter IV, 3.f.	* Page: 26.1.1 *
Approval: Keith W Curtis	Date: APR 19 1986

DESCRIPTION

Parenteral and enteral nutrition therapies are a means of providing nutrition to patients who cannot be fed orally. Parenteral or enteral nutrition is commonly provided to inpatients; however, if the nutrition therapy is required for an extended period of time and the patient's medical condition would not otherwise require hospitalization, parenteral and enteral nutrition therapy can be performed safely and less expensively in the home.

Parenteral Nutrition Therapy: Daily parenteral nutrition therapy is provided to patients with severe pathology of the alimentary tract who are not candidates for enteral nutrition therapy. An indwelling catheter is placed percutaneously in the subclavian vein and then advanced into the superior vena cava where intravenous infusion of nutrients is given for part of the day. The catheter is then plugged by the patient until the next infusion. Following a period of hospitalization, which is required to stabilize the patient, initiate parenteral therapy and to train the patient in catheter care, solution preparation and infusion technique, the parenteral nutrition can be performed safely in the home.

-Continued-

Revision No: Revision Date:

Subject: NUTRITION THERAPIES

Chapter: 1 * Section: 26 * *Page: 26.1.2 *

Enteral Nutrition Therapy: Enteral therapy is provided for a patient with a functioning gastrointestinal tract, but for whom regular, oral feeding is impossible. Enteral therapy is given by nasogastric, jejunostomy, or gastrostomy tubes and can be done safely in the home.

POLICY

Both parenteral and enteral therapies, including the nutrients, are covered when medically necessary for the treatment of a patient with pathology of the alimentary or gastrointestinal tract or who otherwise cannot be fed orally. Coverage may be provided to inpatients, as part of the hospital care, and to outpatients receiving the care at home.

EXCEPTIONS

Coverage may not be provided for a home patient whose condition permits oral feeding. This includes the patient who receives nutritional supplementation in addition to regular meals to increase protein-calorie intake.

POLICY CONSIDERATIONS

1. Medical indications for parenteral nutrition:

Short bowel syndrome
Intestinal obstruction
Inflammatory bowel syndrome
Motility disorder (pseudo obstruction)
Radiation enteritis
Mesenteric infarction
Massive bowel resection

-Continued-

2. Medical indications for enteral therapy:

- Acute ulcerative colitis
- Gastrointestinal cancer
- Chronic infection
- Granulomatous colitis
- Intestinal atresia (infants)
- Ischemic bowel disease
- Malabsorption syndrome
- Acute or chronic pancreatitis
- Fistula
- Irradiated bowel
- Partial obstruction
- Short-gut syndrome
- Head and neck cancer and reconstructive surgery
- Jaw Fracture
- Obstruction of gastric outlet due to ulcer diasthesis
- Renal failure
- Stroke
- Central nervous system disorders

Conditions not appearing on this list may be covered if the attending physician submits adequate documentation of the medical necessity for the service and medical review determines that the services are appropriate for the condition

4. Vitamin or mineral preparations administered by injection or added to the nutrient solutions are also covered. Oral vitamin or mineral preparations are not covered.

5. In the case of the patient receiving parenteral nutrition therapy at home, the reimbursement for the nutrient solutions is limited to the reasonable charge for

-Continued-

the nutrient solutions mixed by the patients themselves (or by a family member). If documentation is submitted by the attending physician that the patient is incapable of mixing or administering the nutrient solutions and that there is no family member available to assist the patient, payment may be made for premixed solutions.

7. Payment may be made for otherwise covered medical supplies and equipment required in the administration of the nutient solutions, e.g., portable infusion pumps, IV stands, administration sets including syringes, needles, tubing, filters, sterile gauze squares, sponges or swabs, testape, padded and regular hemostats, acetone and providone iodine wipes, ointment and similar items.

Subject: DIAGNOSTIC SLEEP STUDIES	Chapter: 1 Section: 26
Authority: DoD 6010.8-R, Chapter IV, A.1.	Page: 26.2.1
Approval: Deputy Director	Date: 12 Oct 84

DESCRIPTION

Sleep disorder studies consist of a clinical examination and polysomnography. The polysomnography is a complex evaluation of a patient during sleep that involves assessing the central nervous sytem, respiratory, cardiac, gastro-intestinal, genito-urinary and endocrine functions and their relationship to sleep stages. These studies are done in a hospital or freestanding clinic. The patients who undergo the testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over.

POLICY

Institutional and professional charges related to sleep diagnostic testing performed in a CHAMPUS-approved hospital are covered only for narcolepsy and documented severe upper airway apnea on an outpatient cost-sharing basis.

EXCEPTIONS

Exclusions.

a. Electrosleep Therapy. Electrosleep therapy is the application of short duration, low-amplitude pulses of direct current to the patient's brain by externally placed occipital electrodes. Passage of the weak electric current through the tissues of the head induces sleep. This modality is considered investigational, as its efficacy has not been established in the United States. Claims for electrosleep therapy must, therefore, be denied.

b. Sexual Dysfunctions. Payment may not be made for any services or supplies

-Continued-

related to impotence, painful nocturnal erections, or any other condition related to a sexual dysfunction or inadequacy.

c. Study, Grant, or Research Programs. Payment may not be made for any services or supplies provided as a part of or under a grant or research program.

d. Noncovered Conditions. Payment may not be made for diagnostic sleep testing of the conditions listed below. These conditions can be diagnosed through other, more appropriate means:

(1) Bruxism (teeth grinding).

(2) Drug dependency.

(3) Enuresis (bed-wetting).

(4) Hypersomnia (pathologically excessive sleep).

(5) Insomnia.

(6) Night terrors or dream anxiety attacks.

(7) Nocturnal myoclonus (muscle jerks).

(8) Restless leg syndrome.

(9) Shift work and schedule disturbances.

(10) Somnambulism (sleepwalking).

(11) Migraine headaches.

e. Freestanding Facilities. Payment may not be made for any sleep diagnostic testing performed in a freestanding facility.

-Continued-

POLICY CONSIDERATIONS:

1. Referral by Attending Physician. The patient must be referred to the sleep disorder center by the attending physician, and the center must maintain a record of the attending physician's orders.

2. Diagnostic Testing. The need for diagnostic testing is confirmed by medical evidence, e.g., physical examinations and laboratory tests. Diagnostic testing that is duplicative of previous testing done by the attending physician, to the extent the results are still pertinent, is not covered.

3. Covered Conditions: Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the conditions listed below.

a. Narcolepsy. This term refers to a syndrome characterized by abnormal sleep tendencies, including excessive daytime sleepiness, disturbed nocturnal sleep and pathological manifestation of rapid eye movement (REM) sleep. The most typical REM sleep manifestations are cataplexy and sleep-onset REM periods, but sleep paralysis and hypnagogic hallucinations may also be present. Related diagnostic testing is covered if the patient has inappropriate sleep episodes (e.g., while driving, in the middle of a meal, in the midst of conversation), amnesiac episodes, or continuous agonizing drowsiness. If the patient has had documented episodes of cataplexy, diagnostic testing would not be necessary and is, therefore, not covered. There must be documentation that the condition is severe enough to interfere with the patient's health and well-being. Ordinarily, a maximum of two clinic sleep sessions is sufficient for diagnosis. Claims in excess of two clinic sleep sessions must be referred to the fiscal intermediary's medical review.

-Continued-

b. Severe Upper Airway Apnea. This is a condition where the patient stops breathing during sleep. The condition may be so severe that the patient requires an emergency tracheostomy. Conditions such as Pickwickian Syndrome (marked obesity) or micrognathia (small jaws), for which corrective surgery is required, may cause severe upper airway apnea and are also covered. Only testing of severe upper airway apnea is covered. Testing of upper airway apnea that is not severe or of lower or middle airway apnea is not covered. Before payment, the clinic must submit documentation of severe upper airway apnea. A maximum of one night stay per patient may be allowed.

Subject: PREMENSTRUAL SYNDROME	Chapter: 1 Section: 26
Authority: DoD 6010.8-R, Chapter IV.G.15	Page: 26.3.1
Approval: Deputy Director	Date: February 26, 1986

DESCRIPTION

Premenstrual Syndrome (PMS) is a constellation of symptoms that encompass emotional, behavioral and physical manifestations. The symptoms occur cyclically immediately before menstruation begins and regress or disappear during menses. The symptoms most frequently associated with PMS are abdominal bloating, edema of the extremities, fullness and tenderness of the breasts, and mood changes. Treatment encompasses a variety of modalities which include somatic and psychological entities. These treatments include but are not limited to vitamin B6, progesterone, bromocriptine, and pyridoxine.

POLICY

CHAMPUS benefits are not available for treatment of the premenstrual syndrome as a defined entity. There are no generally accepted standards for treatment of the syndrome as a defined entity and the treatment approaches have not consistently been shown to be efficacious.

POLICY CONSIDERATIONS

Benefits for otherwise covered, separately diagnosed conditions (e.g. severe depression) should not be denied solely on the basis that they are described as PMS related, and can be cost-shared when medically necessary and appropriate treatment is rendered.

Subject: CRITICAL CARE	Chapter: 1
	Section: 26
Authority: DoD 6010.8-R, ChOPTER IV.	Page: 99160.1.1
Approval: Deputy Director	Date: February 26, 1986

PROCEDURE CODE — 99160 - 99174

DESCRIPTION

Critical care includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate, etc.). Critical care is usually, but not always given in a critical care area such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care unit.

POLICY

Critical care is covered when the patient's condition requires the prolonged presence of the physician in constant attention.

POLICY CONSIDERATIONS

Payment for critical care will cease at the point where the patient's condition is stabilized or the physician is no longer required to be in constant attendance. Reimbursement thereafter will be made for hospital visits at the level of care of the visits. If the patient remains in a critical care setting, payment may be made for more than one daily visit by the same physician; however, more than three daily visits by the same physician are not covered unless the FI's medical review staff determines that frequency of visits were appropriate.

Revision No: Revision Date:

Subject: HYPERBARIC OXYGEN THERAPY	Chapter: 1 * Section: 26 *
Authority: DoD 6010.8-R, Chapter IV, B.l.r., C.l.n.	Page: 99180.1.1
Approval: Keith W Curtis	Date: Oct. 7, 1982

PROCEDURE CODE RANGE	99180 -99182
DESCRIPTION	Hyperbaric oxygen therapy (HBO) is a mode of medical treatment in which the patient is entirely enclosed in a pressure chamber breathing oxygen at a pressure greater than one atmosphere.
POLICY	HBO is covered when provided under certain circumstances and for the specific conditions listed below under policy considerations.
EXCEPTIONS	If treatment exceeds any screen shown as REVIEW POINT, the medical necessity for continued treatment must be documented and the claim submitted to Medical Review. HBO therapy provided for conditions not listed in this policy is not covered by CHAMPUS. Only those hyperbaric oxygen services provided in hyperbaric oxygen chambers situated in authorized hospitals can be covered. Services provided in chambers that are freestanding cannot be covered by CHAMPUS. Topical Application of Oxygen Topical application of oxygen is not considered HBO therapy and is not covered under CHAMPUS.
POLICY CONSIDERATIONS	HBO is covered when provided for the following conditions and under the circumstances outlined

-Continued-

Anemia, exceptional blood loss, due to either hemolysis or exsanguination

Covered only when blood transfusion is impossible or must be delayed (does not include patient refusal of transfusion for religious reasons).

REVIEW POINT: All claims for this condition require Medical Review prior to payment.

Carbon Monoxide poisoning, acute

Covered only when treatment is initiated during the acute episode. More than one treatment may be indicated, but treatment should not exceed 7 days without peer review.

Cyanide poisoning, acute

To be used as an adjunct to standard medical treatment.

Decompression sickness

Gas embolism, acute

Covered only when treatment is initiated during the acute episode.

REVIEW POINT: 10 -14 treatments

Gas Gangrene

Covered for treatment of clostridial gas gangrene with myonecrosis or presumption of same or severe spreading cellulitis with toxicity. To be used only as an adjunct to surgery and antibiotic treatment.

-Continued-

Skin grafts or flaps, compromised
To be used for preparing a granulating base for skin grafting, where viability of graft is compromised or uncertain, or where previous grafts have failed.

REVIEW POINT: Preparation of site for grafting
--20 treatments;
postgrafting--8 treatments.

Smoke inhalation with presumption of carbon monoxide or cyanide poisoning
Covered only when used as an adjunct for the management of carbon monoxide or cyanide poisoning in the presence of a chemical pneumonia.

Meleney's ulcer
Covered only when used as an adjunct to surgical and antibiotic treatment when the bacteriologic diagnosis has been confirmed.

REVIEW POINT: 30 treatments.

Arterial insufficiency, acute peripheral
Covered when used as an adjunct to surgery or as an adjunctive treatment in cases of intra-arterial injection of irritants.

REVIEW POINT: All claims for this condition require Medical Review prior to payment.

Crush Injury
Covered only when used as an adjunct to standard surgical

-Continued-

treatment. Must be initiated within 48 hours of injury.

REVIEW POINT: 20 treatments.

Edema, acute cerebral

Covered only when used as an adjunct to other supportive measures. Presence of cerebral edema at time of treatment must be documented.

REVIEW POINTS: 20 treatments

Osteomyelitis, refractory

Documentation must by submitted which outlines the surgical and antibiotic treatments which have been attempted and which have proven unsatisfactory.

REVIEW POINT: All initial claims must be submitted to Medical Review. If Medical Review determines that HBO is appropriate, claims must be reviewed after 60 treatments.

Osteoradionecrosis

Patient must be referred by appropriate specialist: surgeon, dentist, oral surgeon, ENT specialist or other such provider. Hyperbaric oxygen must be part of an overall plan in which debridement, resection of involved bone, bone grafting, myocutaneous flap reconstruction and specific antibiotic therapy are included as indicated.

REVIEW POINT: 60 treatments.

Peripheral ischemia, acute, traumatic

Covered when used as an adjunct

-Continued-

to surgery or when used post-surgery for not more than 10 days.

REVIEW POINT: All claims for this condition require Medical Review prior to payment.

Suturing severed limbs

REVIEW POINT: 20 days.

Surgical procedures performed in hyperbaric operating room

Payment will be considered only when the procedure is performed in a well-equipped and staffed operating chamber which is fully integrated with an authorized general hospital. All claims for hyperbaric oxygen-supported surgery require Medical Review prior to payment.

CHAPTER 2

ANESTHESIA

CHAPTER 2 - ANESTHESIA

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Subject: HYPNOTHERAPY	Chapter: 2
	Section: 1
Authority: DoD 6010.8-R, Chapter IV, G.15.	Page: 1.1.1
Approval: Deputy Director	Date: 5 Dec 84

POLICY	Hypnotherapy is not an allowable benefit for anesthesia in any circumstance.

Revision No: Revision Date:

Subject: ANESTHESIA ADMINISTERED BY OPERATING SURGEON *	Chapter: 2 Section: 1 *
Authority: DoD 6010.8-R, Chapter IV.C.3.h. *	Page: 1.2.1 *
Approval: Deputy Director	Date: January 23, 1984

POLICY

Administration of anesthesia by the operating surgeon is not covered.

POLICY CONSIDERATIONS

If the surgeon bills a single charge which includes both the surgery and the anesthesia, a breakdown of the charge should be obtained and the anesthesia services denied.

When a breakdown of charges is not available, payment will be based on the allowable charge for the surgery alone.

Revision No: 1 Revision Date: December 5, 1984

CHAPTER 3

SURGERY

CHAPTER 3 - SURGERY AND RELATED SERVICES

SECTION PAGE

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2. Integumentary 10000.1.1
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Subject: COMPLICATIONS (UNFORTUNATE SEQUALAE) RESULTING FROM NONCOVERED SURGERY OR TREATMENT	Chapter: 3
	Section: 1
Authority: DoD 6010.8-R, Chapter IV. E.9	Page: 1.1.1
Approval: Deputy Director	Date: April 11, 1984

POLICY

Benefits are available for the otherwise covered treatment of complications resulting from a noncovered surgery or treatment when:

1. Treatment of the complication is medically necessary; and

2. The complication represents a medical condition separate from the condition that the noncovered treatment or surgery was directed toward; and

3. Treatment of the complication is not essentially similar to the noncovered procedure.

POLICY CONSIDERATIONS

1. A complication may be covered when:

a. The complication causes a systemic effect or occurs in a different body system from the noncovered treatment; and

b. The complication is not expected and is untoward based upon prior clinical experience with the procedure.

2. A complication is not covered when:

a. The complication occurs in the same body system or the same anatomical area of the noncovered treatment; and

b. The complication is one that commonly occurs.

3. A claim falls under the provisions of chapter IV. E.9 when complications are the

-Continued-

result of treatment which was not a covered benefit at the time the services were provided whether or not a claim was processed by CHAMPUS for the noncovered procedure.

4. Common complications that would not be covered when the result of a noncovered treatment include: local infections, defective wound healing, pain, and hypertrophic scars. In addition to these complications, the following are also not covered:

a. Complications from augmentation mammoplasty

(1). Hematoma

(2). Extrusion of prosthesis

(3). Breast firmness

(4). Serous extravasation

(5). Breast assymetry

(6). Nipple anesthesia

(7). Scar contractures

b. Complications from a noncovered rhinoplasty

(1). Hematoma

(2). Hemorrhage

(3). Distortion of nose

(4). Scar contracture

(5). Bony framework deformities

(6). Nasal tip and nostril deformities

-Continued-

c. Complications from a noncovered blepharoplasty

(1). Ectropion

(2). Ptosis

(3). Assymetry

(4). Dry eye syndrome

(5). Hematoma

(6). Enopthalmus

(7). Inclusion cyst formation

5. Examples of untoward and unexpected complications that can be covered when occurring in a different body system than the noncovered treatment was directed toward are:

a. Hypovolemic shock

b. Respiratory insufficiency

c. Cardiac failure or arrest

d. Liver failure

e. Pulmonary embolism

f. Renal failure

g. Phlebitis

Claims for treatment of complications not listed above should be referred for a medical review.

See Vol 1, Chapter 3, Section 2, pages 19184.1.1-19184.1.3 of this Policy Manual for treatment of complications from postmastectomy breast reconstructive surgery. See Vol. 1, Chapter 3, Section 8, pages 43844.1.1-43844.1.3 for complications from surgical treatment of morbid obesity.

Subject: COSMETIC, RECONSTRUCTIVE AND PLASTIC SURGERY - GENERAL GUIDELINES	Chapter: 3 Section: 1
Authority: DoD 6010.8-R, Chapter IV, E.8.	Page: 1.2.1
Approval: Teresa Hawkes Director	Date: 10/22/85

DESCRIPTION

Cosmetic, reconstructive, and/or plastic surgery is defined under CHAMPUS as surgery which can be expected primarily to improve the physical appearance of a beneficiary, and/or which is performed primarily for psychological purposes, and/or which restores form, but does not correct or materially improve a bodily function.

POLICY

Benefits under the CHAMPUS Basic Program are generally not available for cosmetic, reconstructive and/or plastic surgery except under certain limited circumstances. Benefits may be provided for otherwise covered services and supplies provided in connection with cosmetic, reconstructive, and/or plastic surgery, as outlined below in "Policy Considerations".

POLICY CONSIDERATIONS

1. Benefits may be provided for cosmetic, reconstructive, and/or plastic surgery, including otherwise covered services and supplies provided, under the following circumstances.

    a. Correction of a congenital anomaly; or

    b. Restoration of body form (including revision of scars) following an accidental injury; or

    c. Revision of disfiguring and extensive scars resulting from neoplastic surgery (excluding augmentation mammoplasty).

-Continued-

Subject: COSMETIC, RECONSTRUCTIVE AND PLASTIC SURGERY GENERAL GUIDELINES

Chapter: 3 Section: 1 Page: 1.2.2

2. Generally, benefits are limited to those cosmetic, reconstructive, and/or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury occurred, except for authorized postmastectomy reconstructive breast surgery for which there is no time limitation between mastectomy and reconstruction. (See Section 2, page 19160.1.1 of this Chapter 3.) Also, special consideration will be given to cases involving children who may require a growth period.

3. Preauthorization is not required for these services.

4. For the purpose of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion are specifically excluded. Also excluded are any procedures related to transsexualism or hermaphroditism, except as otherwise specifically provided in Chapter IV, E.7. of the CHAMPUS Regulation 6010.8-R. Also, see Section 11, Page 55970.1.1 and Section 12, page 56000.1.3 of this Chapter 3.

5. Cosmetic, reconstructive, and/or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process are also excluded.

6. Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies are also excluded.

7. In addition, whether or not they would otherwise qualify for benefits under the criteria of this issuance, the breast augmentation mammoplasty, surgical

-Continued-

insertion of prosthetic testicles and the penile implant procedure are specifically excluded.

8. When it is determined that a cosmetic, reconstructive and/or plastic surgery procedure does not qualify for CHAMPUS benefits, all related services and supplies are excluded, including any institutional costs.

9. The following is a partial list of cosmetic, reconstructive, and/or plastic surgery procedures which do not qualify for benefits under CHAMPUS. This list is for example purposes only, and is not to be construed as being all-inclusive.

a. Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age and/or ethnic and/or racial background.

b. Cosmetic, reconstructive and/or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

c. Face lifts and other procedures related to the aging process.

d. Reduction mammoplasties (unless there is medical documentation of intractable pain not amendable to other forms of treatment, as the result of increasingly large pendulous breasts). See Section 2, Page 19318.1.1 of this Chapter 3.

e. Panniculectomy; body sculpture procedures.

-Continued-

f. Repair of sagging eyelids (without demonstrated and medically documented significant impairment of vision). See Section 2, Page 15820.1.1 of this Chapter 3.

g. Rhinoplasties, except as detailed in Section 4, Page 30400.1.1 of this Chapter 3.

h. Chemical peeling for facial wrinkles.

i. Dermabrasion of the face, except as outlined in Section 2, Page 15780.1.1 of this Chapter 3.

j. Revision of scars resulting from surgery and/or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

k. Removal of tatoos.

l. Hair transplants.

m. Electrolysis.

n. Penile implant procedure. See Section 10, Page 54000.1.2 of this Chapter 3.

o. Insertion of prosthetic testicles. See Section 10, Page 54000.1.2 of this Chapter 3.

10. The following information must be submitted with claims for cosmetic, reconstructive and plastic surgery. Beneficiaries are not required to submit this documentation with each claim submitted for the same episode of care. Fiscal intermediaries must use standard

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development procedures to determine if this information has previously been submitted (See Chapter 1, Part Two, Section V of the COM-FI for more detailed information on claims development.) Submission of this information will save time and result in faster payment of the claim, if warranted.

a. A medical statement by the physician which includes the following.

(1) Brief medical history.

(2) Condition.

(3) Date of injury.

(4) Symptoms.

(5) Length of time symptoms were present.

(6) Other forms of treatment attempted.

(7) Operative report.

b. Photographs, if available.

11. Submission of the above information is not required on each claim for the same episode of care, i.e., anesthesia, radiology, etc. Fiscal intermediaries are required to use standard development procedures to determine if previous claims for the same procedure have been submitted which contain the above information.

12. The above listed criteria/guidelines are general guidelines. Additional guidelines applicable to specific procedures are discussed throughout this Chapter 3 under the title of the procedure.

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13. Fiscal intermediaries are required to apply guidelines on all cosmetic, reconstructive and plastic surgery claims, either through specific criteria for nonmedical staff, or referral to medical review, where necessary to make an accurate benefit decision.

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VOLUME I

6010.47-M

Subject: INTEGUMENTARY SYSTEM	Chapter: 3
	Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 10000.1.1
Approval: Robert D Seamon for Director	Date: August 26, 1985

PROCEDURE CODE RANGE

10000 - 19499

DESCRIPTION

Integumentary system pertains to the skin, subcutaneous tissue and areolar tissue.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the integumentary system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Excision of Skin Lesions.

a. The excision of skin lesions is covered when medically necessary and not performed for cosmetic purposes. Reimbursement is based on the location of the lesion, size of the lesion, whether the lesions are benign or malignant, and the type of skin closure.

b. Claims or supporting documents that do not specify the size and location of the lesion excised will be developed for additional information.

2. Topical Treatment for Removal of Skin Lesions.

Topical treatment for the removal of skin lesions by 5-fluorouracil or other methods in the form of lotions, salves, or

-Continued-

Revision No: Revision Date:

ointments, is not covered as an independent procedure. This service is included in the reimbursement for an office visit.

2. Excision of Multiple Lesions.

a. Excision of multiple lesions (11200-11646) performed during one operative session or the removal of benign skin lesions by destruction are reimbursed on the following basis:

(1) 1st lesion - 100% allowance.

(2) 2nd lesion - 50% of allowance.

(3) 3rd lesion and each additional lesion - 25% of allowance.

b. For removal of benign lesions by destruction (17000-17999), the above reimbursement basis should be applied for all lesions destroyed by the same physician subsequently for a 15-day period.

3. Removal of Lesions by Shave Method.

Removal of skin lesions by the shave method is covered, and reimbursement will be on the basis of an excision of a benign lesion with simple closure.

4. Tissue Examinations.

Tissue examinations performed by the operating physician in conjunction with excision procedures are covered.

5. Biopsy of Skin Lesion.

a. Biopsy of a skin lesion is covered as an independent procedure. Reimbursement for a biopsy of a skin lesion which is performed on the same day that the biopsied

-Continued-

lesion is removed, when performed by the operating physician, is included in the allowance for the excision of the lesion.

b. A biopsy performed on the same day that a different lesion is removed, is reimbursed on the following basis:

(1) 100% of the allowance for the procedure with the highest value.

(2) 50% of the allowance for the second procedure with the next highest value.

(3) 25% of the allowance for each additional procedure.

6. Malignant Skin Lesions.

Excision or removal of malignant skin lesions performed on an outpatient basis is a covered service, provided a positive pathologist report from a physician, other than the operating physician, accompanies the claim. Claims received without a pathological report are to be reimbursed as removal of a benign lesion.

7. Treatment of Warts.

Treatment of warts (17000-17110), including plantar warts, by surgical excision or other methods, is a covered service if performed for other than cosmetic reasons.

8. Moh's Chemosurgery.

Moh's chemosurgery technique for excision of malignant skin lesions (17300-17301) is a covered service.

-Continued-

Reimbursement is based on the initial lesion size, body area location, and the number of microscopic sections submitted for all subsequent stages of removal.

9. Incision and Drainage of Postoperative Abscess.

If an incision and drainage of a postoperative abscess are performed within the 72-hour period immediately following the surgical procedure, reimbursement is included in the allowance for the surgical procedure.

10. Excision of Lesion or Scar/Free Skin Graft.

Excision of a skin lesion or covered excision of a scar performed during the same operative session as a free skin graft by the same physician, is covered. Reimbursement will be based upon 100% of the allowance for the free skin graft (15050-15416) and 50% of the allowance for the excisional procedure (15000).

11. Routine Foot Care.

a. Services rendered for routine foot care (e.g., trimming of nails, treatment of corns, treatment of calluses, hygenic and preventive maintenance, and the use of skin creams) are not covered regardless of whether the services are performed by a physician or a podiatrist.

b. An exception is made when the performance of such routine foot care may pose a hazard to patients with certain systemic conditions. When the following systemic conditions are present, the services will be considered a benefit.

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(1) Diabetes mellitus with severe vascular disease.

(2) Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis).

(3) Buerger's disease (Thromboangitis obliterans).

(4) Chronic thrombophlebitis.

(5) Patients on anticoagulants.

(6) Severe arthritis with functional impairment and circulatory impairment.

(7) Peripheral neuropathies involving the feet:

(a) Associated with malnutrition and vitamin deficiency (general pellagra).

(b) Alcoholism.

(c) Malabsorption syndrome (celiac disease, tropical sprue).

(d) Pernicious anemia.

(e) Patients on cancer chemotherapy.

(f) Associated with malignancy.

(g) Associated with multiple sclerosis.

(h) Associated with uremia (chronic renal disease).

-Continued-

(i) Associated with traumatic injury.

(j) Associated with leprosy or neurosyphilis.

(k) Associated with hereditary disorders such as hereditary sensory radicular neuropathy, angiokeratoma corporis diffusum (Fabry's disease or syndrome), and amyloid neuropathy (heredity neuropathic amyloidesis).

(8) Severe neurological impairment, e.g., stroke, spinal cord injury with impaired sensation and risk of infection.

(9) The claim must have the diagnosis and name of the doctor of medicine or doctor of osteopathy attending the patient for the disease.

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VOLUME I

6010.47-M

Subject: COLLAGEN IMPLANTATION	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.1.	Page: 11950.1.1
Approval: For Maurice [illegible] Executive Officer Deputy Director	Date: June 4, 1984

PROCEDURE CODE RANGE 11950 - 11954

DESCRIPTION	Collagen implantation is the injection of a purified and processed bovine (cattle) skin into the tissues (skin) to restore the natural contour which has been damaged by age, trauma, disease, congenital anomalies or previous therapeutic processes.
POLICY	Collagen implantation (e.g., Zyderm) is not covered under CHAMPUS. The long term safety and efficacy are not known.

Revision No:	Revision Date:

Subject: DERMABRASION	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV. E.8	Page: 15780.1.1
Approval: Deputy Director	Date: April 19, 1983

* PROCEDURE CODE RANGE	15780 - 15787 *
DESCRIPTION	The planing of the skin by mechanical means, e.g., sandpaper, wire brushes, etc.
POLICY	Dermabrasion is covered under CHAMPUS on a limited basis.
EXCEPTIONS	In those circumstances where coverage has been authorized for cosmetic, reconstructive and/or plastic surgery required to restore body form following an accidental injury or to revise disfiguring and extensive scars resulting from neoplastic surgery, dermabrasion which is necessary to effect the full reconstructive goals of the surgery is covered.

Revision No: 1 Revision Date: June 4, 1984

Subject: BLEPHAROPLASTY	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.2. & E.8.	Page: 15820.1.1
Approval: Teresa Hawkes Director	Date: 10/23/85

PROCEDURE CODE RANGE	15820 - 15823 67916 - 67917 67923 - 67924 67930
DESCRIPTION	Plastic surgery of the eyelids.
POLICY	Blepharoplasties are not covered except when significant impairment of vision is medically documented.
POLICY CONSIDERATIONS	1. Claims submitted for reimbursement of a blepharoplasty must include the following: a. Two visual field studies: one with and one without lid elevation. b. Photographs, if available, showing the full face 3-way view; AP, right and lateral views. 2. Claims with documentation of 15 degree or more compromise of the superior visual field may be paid without further justification. Claims with less than 15 but more than 5 degree compromise of the superior visual field are subject to medical review. Less than 5 degree compromise will be denied.

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3. The following surgical descriptions are considered primarily functional:

a. Levator shortening procedure for ptosis.

b. 7th nerve palsy repair.

c. Epiblepharon and ectropion procedures.

4. The following surgical descriptions are not functional and are considered primarily cosmetic in nature.

a. Orbital fat removal.

b. Supratarsal fixation.

c. Lower lid blepharoplasty. (Denial subject to medical review.)

d. Eyebrow lift (if done in conjunction with 7th nerve palsy repair, subject to medical review.

Subject: POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV, E.8.a.(4)	Page: 19160.1.1
Approval: Deputy Director	Date: October 7, 1982

* PROCEDURE CODE RANGE	19160 - 19240 * 19340 - 19499 *
DESCRIPTION	Breast reconstruction consists of both mound reconstruction and nipple-areola reconstruction. Reconstruction of the nipple-areola complex is not considered a separate entity from breast reconstruction, rather it is an integral part of it. The intent behind breast reconstruction is to reconstruct an absent breast. If the nipple is also absent, then its reconstruction is also a part of the absent breast.
POLICY	Payment may be made for post-mastectomy reconstruction of the breast when the mastectomy was performed as a result of carcinoma, fibrocystic disease, other nonmalignant tumors, or traumatic injuries.
EFFECTIVE DATE	October 1, 1980
POLICY CONSIDERATIONS	Reconstruction may be covered regardless of the type of mastectomy performed. Payment may be made for a musculocutaneous flap transfer for patients who have undergone a radical mastectomy. Any implant material used must be approved for use in humans by the Food and Drug Administration. Generally, coverage will be limited to two procedures per breast, unless medical indications require more than two procedures.

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Payment may be made for treatment of complications following reconstruction (including implant removal) regardless of when the reconstruction was performed.

The allowable charge for bilateral reconstruction performed at the same operative session may not exceed 150 percent of the reasonable charge for a unilateral procedure.

Preauthorization is not required.

Claims which are not sufficiently documented to enable a coverage determination will be developed by a request for additional information. Failure to provide the information requested will result in denial of the claim.

Payment may be made for the implant material and or prosthesis when billed separately by the physician when an invoice is attached and then only at the invoice cost. In bilateral cases, the multiple surgery guidelines apply only to the implant procedure - all materials should be reimbursed at invoice cost. In all other cases, the cost of the implant will be considered an institutional expense.

* Claims for mastectomies with immediate *
* reconstruction will be processed as one *
* procedure although listed in the 1984 *
* version of the "Physicians' Current *
* Procedural Terminology, Fourth Edition" *
* as two separate procedure codes. *
* Multiple surgical guidelines will not *
* apply in this instance. *

Subject: REDUCTION MAMMOPLASTY	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV, C.2. & E.8.	Page: 19318.1.1
Approval: Teresa Hawkes Director	Date: 10/22/85

PROCEDURE CODE 19318

POLICY

Reduction mammoplasty is not covered unless there is medical documentation of intractable pain, not amenable to other forms of treatment, which is the result of excessively large, pendulous breasts.

POLICY CONSIDERATIONS

1. The following criteria will be applied to all claims for reduction mammoplasties in determining CHAMPUS coverage. The beneficiary must submit documentation, generally an operative report will contain needed information, of this criteria with each claim to avoid delays in development.

a. History of the patient's symptoms related to the large, pendulous breasts.

(1) Neck and shoulder pain.

(2) Low back pain.

(3) Strap mark indentations.

(4) Restriction of physical activities.

(5) Poor posture or skin irritation.

b. Symptoms must have been present at least one year to be considered intractable.

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c. Suprasternal notch to nipple measurement must be at least 21 cm.

d. Amount of breast tissue removed must be at least 450 grams per side. Claims with less will be referred to medical review for a determination.

e. Photographs (shoulder to waist) front and lateral views, if available.

2. Reduction mammoplasties are not generally considered to be the treatment of choice for fibrocystic disease of the breasts.

3. Reduction mammoplasty is not a treatment for obesity.

4. Mastopexy procedures are primarily cosmetic in nature and are not payable.

5. Fiscal intermediaries are required to apply specific guidelines on all claims as outlined in Section 1, Page 1.2.6 of this Chapter 3.

Subject: BREAST CONSTRUCTION AS A RESULT OF A CONGENITAL ANOMALY	Chapter: 3 Section: 2
Authority: DoD 6010.8-R, Chapter IV, E.8.	Page: 19360.1.1
Approval: Deputy Director	Date: April 16, 1986

PROCEDURE CODE	19499
DESCRIPTION	A congenital anomaly is a marked deviation from the normal standard, existing at, and usually before, birth.
POLICY	CHAMPUS benefits are authorized for constructive breast surgery when absence of the breast exists due to a congenital anomaly.
POLICY CONSIDERATIONS	1. Documentation must be submitted with each claim showing that a congenital anomaly existed which resulted in agenesis of the breast, i.e., Poland's syndrome. 2. Reconstructive breast surgery for incomplete or underdevelopment (hypoplasia) of the breast is not authorized under CHAMPUS. 3. General policy guidance for cosmetic, reconstructive, and plastic surgery is at Chapter 3, Section 1, Page 1.2.1 of this Volume One. Chapter 3, Section 2, Page 19160.1.1 of this Volume One contains policy for postmastectomy reconstructive breast surgery.

Revision No: Revision Date:

Subject: MANDIBULAR STAPLE IMPLANT	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, E.10.	Page: 3.1.1
Approval: Keith W Curtis Deputy Director	Date: April 11, 1984

DESCRIPTION	A mandibular staple implant (bone plate) is an implantable device to be used as a prosthetic fastener system for dentures.
POLICY	Mandibular staple implants are not covered because their primary purpose is to prepare the mouth for dentures, a service which is excluded by CHAMPUS.

Revision No: Revision Date:

Subject: MUSCULOSKELETAL SYSTEM	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 20000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 20000 - 29799

DESCRIPTION The musculoskeletal system pertains to or comprises the skeleton and the muscles.

POLICY Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the musculoskeletal system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS 1. Joint Injections.

a. Arthrocentesis, aspiration or injection (20600-20610), is reimbursed as follows:

(1) Only one injection per joint is covered on the same day.

(2) Multiple joints injected will be reimbursed at 100% of the allowance for each joint, up to three joints.

(3) Each joint injected over three will be reimbursed at 50% of the allowance for each.

b. Therapeutic injections of the same joint are limited to a maximum of two per month for three months. Further payment for injections into the same joint within six months requires documentation and Medical Review.

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c. Daily aspirations of infected joints may be paid for a maximum of five days. The medical necessity for further aspiration on a daily basis must be documented for Medical Review.

2. Aspiration of Joint/Closed Reduction of Fracture.

When aspiration of a joint is performed in conjunction with a closed reduction of a fracture of a joint, reimbursement will be 100% of the allowance for the closed reduction, and 50% of the allowance for the aspiration. When the aspiration is performed on a day subsequent to a closed reduction of a joint, reimbursement for the aspiration will be 100% of the allowance.

3. Treatment of Fracture - Inpatient.

The treatment of simple or compound fractures, by closed or open methods on an inpatient basis includes the following and separate charges are not payable:

(1) Application and removal of the initial cast.

(2) Traction devices.

(3) Suturing of the skin.

(4) Uncomplicated follow-up visits.

(See paragraphs 8, 9, and 12 of this issuance for policy concerning treatment provided by more than one physician.)

4. Treatment of Fracture - Outpatient.

Reimbursment for treatment of simple or compound fracture, by closed or open

-Continued-

methods performed on an outpatient basis includes the following and no separate payment may be made:

(1) Reduction, where indicated.

(2) Pin, wire, metal band, screw (insertion).

(3) Simple repair of a wound.

(4) Application and removal of a cast.

(5) Uncomplicated follow-up office visits.

5. Multiple Fractures Requiring Surgery.

Surgical procedures, closed or open, performed in the treatment of multiple fractures, will be reimbursed at 100% of the allowance for the procedure with the highest value and 50% of the allowance for the procedure with the lesser value.

6. Reduction or Repair of Fractured or Dislocated Digit.

A surgical procedure for the reduction of a fractured or dislocated digit with soft tissue closure, or the repair of a compound or comminuted fracture of the digit includes the removal of the nail and repair of the laceration with the fractured digit.

7. Removal of Nail/Closed Reduction.

The removal of a finger or toenail (11730-11732) when performed in conjunction with a closed reduction of a digit is reimbursed at 50% of the allowance for the procedure.

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8. Second Reduction - Same Surgeon.

A surgical procedure performed as a second reduction of a previously reduced fracture, by the same physician, is reimbursed at 100% of the allowance, provided the second reduction (open or closed) is performed under general or regional anesthesia, and on a day subsequent to the initial reduction. Additional re-reduction performed by this same physician is reimbursed at 50% of the allowance.

9. Second Reduction - Different Surgeon.

A surgical procedure performed as a second reduction of a previously reduced fracture, by a physician other than the physician performing the initial reduction, is reimbursed at 100% of the allowance regardless of the date of the original reduction or the number of reductions performed by the initial physician prior to this procedure. Additional reductions performed by this different physician are reimbursed at 50% of the allowance.

10. Hospital Visits for Complications.

Hospital visits, pre- or postoperative, may be covered for the care of complications. These claims require documentation as to medical necessity, level of care rendered, and procedures performed, for Medical Review.

11. Casts Applied After Initial Cast.

A cast applied subsequent to the initial cast, in the office or in the hospital, is covered. The allowance includes reimbursement for the application of the cast and the cost of the cast supplies.

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12. Cast Removal.

Cast removal is included in the initial allowance for application of the cast. In instances where the cast was applied in one geographical location and the removal must be done in another geographical location, a separate benefit payment may be provided for the removal. Benefits are not available for the services of a second provider if those services could have reasonably been rendered by the provider who initially applied the cast.

13. Office Visits During Follow-up Period.

Routine office visits related to fracture care are not covered when rendered by the primary physician during the specified follow-up period, the extent of which is generally based upon local practice.

14. Incision and Drainage.

Incision and drainage procedures related to the reduction of a fracture are not considered routine fracture care and are covered, beginning 72 hours after the procedure. Services provided during the first 72 hours are considered incidental to the reduction and included in the global fee.

15. X-Rays.

X-rays, including interpretations, are covered only when disease or injury is present or suspected. Payment is made in addition to the allowance for the surgical procedure. An x-ray of the foot not specified as to the number of views should be classified as "radiologic examination, foot; anteroposterior and lateral views" (73620).

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16. Comparison X-Rays.

X-ray views taken of the part of the body contralateral to the affected area may be indicated in cases of developmental abnormality or of trauma to children. Payment should be made for a "limited" x-ray series of the contralateral part when comparison x-rays are billed. If comparison x-rays are billed at a level above "limited," the claim should be referred to Medical Review.

17. Prolotherapy, Joint Sclerotherapy and Ligamentous Injection with Sclerosing Agents.

Prolotherapy, joint sclerotherapy and ligamentous injection with sclerosing agents are not covered. (See Chapter 8, Section 14, Page 14.1.3 of this Volume I.)

18. Hammer Toe Surgery.

a. Correction of a "Hammer Toe" (28285-28286) is a covered surgical procedure and is reimbursed in addition to a tenotomy when performed through separate incisions. If more than one tenotomy is done through the same incision during the same operative session, reimbursement will be made for only one tenotomy.

b. An operative report is required for all hammer toe surgery. The report must include:

(1) Indications for surgery.

(2) Findings at surgery.

(3) Operative technique.

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19. Surgical Implant Devices.

Surgical implant devices are covered and reimbursed at actual cost as shown by an invoice. Payment may be made to the hospital where the surgery was performed or to the provider (or beneficiary), if the cost of the device represents an out-of-pocket expense to the physician. The device must be approved for use in humans by the Food and Drug Administration.

20. Treatment of "Flat Foot" Conditions.

The following services for treatment of flat feet are not covered.

(1) Treatment of pes planus (flat feet).

(2) Correction of subluxation (flat feet, surgical or non-surgical).

NOTE: Treatment of subluxation of the foot should not be confused with treatment of an acute dislocation of the foot.

21. Windowing of a Cast.

Windowing of a cast (29730) is not covered.

22. Bunionectomy.

a. Bunionectomy is covered and paid at different levels, as follows:

(1) Simple (Silver procedure) (28290)

(2) Modified (Keller, McBride or Mayo type procedure) (28292).

-Continued-

(3) Radical (Joplin procedure) (28294).

b. Bunionectomy, if the level is not identified, is classified as "simple" (28290).

23. Tendon-Lengthening Procedures.

a. Tendon-lengthening procedures or tenotomies of the extensor tendons (28234) are included in the reimbursement for a bunionectomy, metatarsophalangeal joint, or metatarsal procedures. Tendon lengthening or tenotomy of the flexor tendon is covered during these procedures only if a separate incision is made.

b. Tenotomies for claw toes, asymptomatic or passively correctable, are not covered.

c. Tendon-lengthening procedures or tenotomy, when performed on two adjacent tendons, are reimbursed as one procedure.

d. An operative report is required for all tendon-lengthening procedures.

24. Surgical Procedures on the Brevis Tendon.

Surgical procedures on the brevis tendon are not covered.

25. Insertion of Joint Prosthesis.

An additional professional allowance may be made for insertion of a joint prosthesis in the metatarsophalangeal joint. The additional allowance will not exceed two allowances per foot.

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26. Subungual Ostectomy.

A subungual ostectomy is a covered service and reimbursement includes allowance for removal of the toenail or matrix of the nail. A subungual ostectomy is classified as "ostectomy of a digit, toe."

27. Sesamoidectomy.

A sesamoidectomy is a covered service only when not performed in conjunction with other foot surgery.

28. Excision of Neuroma

Excision of a neuroma is covered when verified by a pathology report. When there is no pathology report, the excision will be classified as "excision, tumor, benign, deep, subfascial or intra-muscular" and reimbursed appropriately.

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VOLUME I

6010.47-M

Subject: Oral Surgery of the Temporomandibular Joint	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, E.10.d.	Page: 20605.1.1
Approval:	Date: APR 19 1[illegible]

PROCEDURE CODE RANGE	20605, 21010, 21011, 21050, 21051, 21060, 21061, 21240, 21241, 21480, 21490
DESCRIPTION	Surgical treatment of the temporal bone and the lower bone of the jaw.
POLICY	Surgical treatment of the temporomandibular joint is covered when any of the following conditions are present: 1. Osteoarthritis - Claims with this diagnosis should be referred to medical review to verify the medical necessity of surgical intervention. 2. Trauma 3. Congenital causes, e.g., agenesis or hypoplastic condyle 4. Ankylosis 5. Tumors 6. Dislocations
EXCEPTIONS	Treatment of temporomandibular joint syndrome, occlusal equilibration and restorative occlusal rehabilitation are excluded from this category.
POLICY CONSIDERATIONS	The fiscal intermediary responsible for CHAMPUS claims in the geographical area in which the care is received is charged with adjudication of these oral surgery claims. Preauthorization is not required.

Revision No:	Revision Date:

Subject: MANDIBULAR BONE GRAFTS	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, E.10.	Page: 21215.1.1
Approval: Keith W Curtis Deputy Director	Date: April 11, 1984

PROCEDURE CODE	21215
DESCRIPTION	Removal of tori or grafting bone to jaw structure.
POLICY	Only mandibular bone grafts performed for other than orthodontia or dental support are eligible for benefits. Examples of covered reconstruction include that necessitated as a result of a fracture, accidental injury or tumor removal.

Revision No: Revision Date:

Subject: PECTUS EXCAVATUM	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, E.8.a.(1) & b.(3)	Page: 21740.1.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

PROCEDURE CODE RANGE	21740 - 21741
DESCRIPTION	Pectus excavatum is an undue depression of the sternum called "hollowed breast," funnel breast or funnel chest. It is a congenital skeletal defect in which the sternum is depressed into the thoracic cavity by abnormal partial developmental dislocation of the joints between the ribs and the sternum.
* POLICY	Surgery to correct the skeletal defect can be covered as correction of a congenital anomaly when the defect is more than a minor anatomical anomaly. Documentation of the degree or severity of the skeletal defect is required. *
* EXCEPTIONS	Breast augmentation due to the congenital absence of the pectoralis major and minor muscles is not covered. *
* POLICY CONSIDERATIONS	The degree of skeletal deformity in pectus excavatum can be documented by photographs, radiographs, cardiac and pulmonary function tests, or a narrative description by a physician. * Any case in which there is a question on the severity of the skeletal defect shall be referred for a medical review. *

Revision No: 1 Revision Date: August 26, 1985

Subject: NEUROMUSCULAR STIMULATION FOR SCOLIOSIS	Chapter: 3 Section: 3
Authority: DoD 6010.8-R, Chapter IV, D.3.b.	Page: 22899.1.1
Approval: Deputy Director	Date: March 12, 1985

PROCEDURE CODE	22899
DESCRIPTION	Neuromuscular stimulation is the use of surface electrical stimulation to the lateral spinal musculature or deep muscle stimulation to the paraspinal musculature following implantation of a radio receiver into the subcutaneous paraspinal muscles to halt or reverse spinal curvature.
POLICY	Surface neuromuscular stimulation for idiopathic scoliosis in pediatric and adolescent patients is covered under CHAMPUS on a case-by-case basis subject to review for medical necessity.
EFFECTIVE DATE	June 22, 1984.
POLICY CONSIDERATIONS	1. The neuromuscular stimulator will be cost shared under the durable medical equipment guidelines. See page 3.1.1 in Section 3 of Chapter 7 of this manual. 2. The treatment of scoliosis with implanted electrical muscle stimulation is considered experimental and is not covered under CHAMPUS.

Revision No: Revision Date:

Subject: DENIS-BROWNE SPLINT	Chapter: 3
	Section: 3
Authority: DoD 6010.8-R, Chapter IV, D.3.h.	Page: 29590.1.1
Approval: Keith W Curtis	Date: NOV 01 1983

PROCEDURE CODE	29590
POLICY	A Denis-Browne splint is covered under CHAMPUS as an orthopedic brace in connection with Talipes Equinovarus, a type of clubfoot.
POLICY CONSIDERATIONS	Replacement shoes are covered when necessary due to growth of a child's foot. Claims for shoes must be developed to document that the shoes are attached as an integral part of the brace.

Revision No:	Revision Date:

Subject: RESPIRATORY SYSTEM	Chapter: 3 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 30000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 30000 - 32999

DESCRIPTION

The respiratory system is the tubular and cavernous organs and structures by means of which pulmonary ventilation and gas exchange between ambient air and the blood are brought about.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the respiratory system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Laryngoscopy.

a. Laryngoscopy and related procedures (31515-31599) are covered. When a laryngoscopy is performed in conjunction with a bronchoscopy (31620 -31659) during the same surgical session, reimbursement will be 100% of the procedure with the highest value only.

b. Indirect laryngoscopy (31505) when billed as an independent procedure, is reimbursed on the same basis as an office visit, limited, established patient. When billed in conjunction with an office visit, reimbursement for the indirect laryngoscopy is included in the reimbursement for the office visit.

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2. Bronchoscopy.

Bronchoscopy (31620-31659) is a covered service and reimbursement is the same regardless of the type of instrument used (flexible or rigid bronchoscope). When a bronchoscopy is performed in conjunction with an esophagoscopy (43200-43228) or a tracheostomy (31600-31614), reimbursement will be 100% of the allowance for the procedure with the highest value only.

3. Bronchoscopy/Lobectomy.

When a bronchoscopy (31620-31659) is performed in conjunction with a lobectomy (32480-32490), the bronchoscopy will be paid at 50% of its usual allowance. If performed at the completion of the lobectomy for bronchial toilet, no additional fee will be allowed.

4. Bronchial Brushing.

The bronchial brushing technique (31627) to obtain cytologic specimens from the bronchial tree is covered. Reimbursement is included in the allowance for the bronchoscopy.

5. Transbronchial Lung Biopsy.

A transbronchial lung biopsy (31628) is a covered service. When performed in conjunction with other surgery, multiple surgery guidelines will apply.

6. Bronchopulmonary Lavage.

Bronchopulmonary lavage, complete or segmental, is a covered service. When performed in conjunction with other surgery, multiple surgery guidelines will apply.

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7. Thoracotomy/Thoracic Surgical Procedures.

When a thoracotomy (32095-32160) is billed in conjunction with another major thoracic (chest) procedure, payment will be made only for the procedure with the highest value.

Subject: RHINOPLASTY	Chapter: 3 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.2. & E.8.	Page: 30400.1.1
Approval: Teresa Hawkes Director	Date: 10/23/85

PROCEDURE CODE RANGE 30400 - 30450

DESCRIPTION

A plastic surgical operation on the nose, either reconstructive, restorative or cosmetic.

POLICY

1. Rhinoplasties are not covered except:

    a. When required due to accidental injury occurring within the previous 6 months which resulted in significant obstruction of breathing, or

    b. The attending physician documents that the rhinoplasty was an integral part of an internal procedure to restore function.

2. Rhinoplasties and internal procedures on the nose must restore function in order to be CHAMPUS benefits.

POLICY CONSIDERATIONS

1. Claims for reimbursement of a rhinoplasty must include the following:

    a. Photographs showing the standard 4-way view: base of nose, AP, and right and left lateral views, if available.

    b. Signed medical statement to include history of recent trauma, the dates of injury, dates of related surgeries, degree of nasal obstruction, and other symptoms of breathing obstruction such as nasal stuffiness, dryness, mouth breathing, etc.

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c. Operative report.

2. Fiscal intermediaries are required to apply specific guidelines on all claims as outlined in Section 1, Page 1.2.6 of this Chapter 3.

EXCEPTIONS

1. The following surgical descriptions are not functional and are considered primarily cosmetic in nature.

a. Alar tip cartilage repair.

b. Dorsal hump removal.

c. Shortening of the nasal septum.

d. Narrowing of the bony pyramid.

e. Nasal tip reconstruction.

f. Repair of unrecognized trauma, that is, trauma which is not related specifically to time or event.

g. Saddle nose deformity.

Subject: CARDIOVASCULAR SYSTEM	Chapter: 3 Section: 5
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 33010.1.1
Approval: Robert D Seanor for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 33010 - 37799

DESCRIPTION

The cardiovascular system involves the heart and blood vessels, by which blood is pumped and circulated through the body.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the cardiovascular system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Cardiopulmonary Bypass.

A cardiopulmonary bypass procedure performed independently is a covered service. When performed in conjunction with other related cardiovascular surgery, reimbursement is included in the basic allowance for the procedure with the highest value.

2. Insertion of a Permanent Cardiac Pacemaker.

a. Insertion of a permanent cardiac pacemaker (33200-33208) is a covered service. Repositioning or replacement (33216) in the first fourteen postoperative days is included in the basic allowance to the primary surgeon, or a member of his/her professional association of the same specialty, for the primary surgery.

-Continued-

b. All pacemakers replaced because of failure during the first 14 postoperative days will be disallowed routinely unless accompanied by documentation of equipment failure confirmed by Medical Review.

3. Insertion of Temporary Cardiac Pacemaker Electrodes.

Insertion of temporary cardiac pacemaker electrodes (33210) is a covered service and reimbursement will be at 100% of the allowance for the initial insertion. Subsequent insertions of temporary pacemaker electrodes by the primary surgeon or a member of his/her professional group of the same specialty during the same hospital admission are to be reimbursed by the following criteria:

(1) 50% of the allowance for the second insertion; and

(2) 25% of the allowance for all other insertions.

4. Insertion of Internal Pacemaker with Epicardial Electrodes.

a. Insertion of an internal pacemaker with epicardial electrodes (33200-33201) by the primary surgeon, or a member of his/her professional group of the same specialty, is a covered service.

b. When performed in conjunction with a thoracotomy (32095), reimbursement will be for the procedure with the highest value only.

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5. Coronary Artery Procedures/Coronary Endarterectomy or Coronary Angioplasty.

a. Coronary artery procedures (33502-33528) performed in conjunction with coronary endarterectomy are covered services. (See Chapter 4, Section 2, Page 75972.1.1 of this Volume I.)

b. Reimbursement will be for the procedures with the highest value only.

6. Incidental Surgical Procedures.

a. Reimbursement for certain surgical procedures, when performed incidental to other surgical procedures by the operating surgeon or his assistant, is included in the basic allowance for the major procedures.

b. The most common (but not all) such procedures are listed below:

(1) Operative central venous pressure catheter placement (36480-36510) with any major surgery.

(2) Arterial catheterization (or cannulization) for monitoring (36620) with any major surgery.

7. Arterial Resection/Endarterectomy or Thrombectomy.

a. An arterial resection with graft replacement or with a bypass graft is a covered service.

b. When performed in conjunction with an endarterectomy or thrombectomy and/or removal of veins, to be used for the bypass graft, reimbursement is for the procedure with the highest value only.

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8. Aortic Surgery/Thoracolumbar Sympathectomy.

When a thromboendarterectomy (or thrombectomy) of the abdominal aorta (35331) or any other aortic surgery is performed during the same operative session as a thoracolumbar sympathectomy (64809-64811), reimbursement is for the procedure with the highest value only.

9. Extremity Artery Procedures/Lumbar Sympathectomy.

When extremity artery procedures are performed in conjunction with a lumbar sympathectomy (64818-64819), reimbursement is 100% of the allowance for the procedure with the highest value and 50% of the allowance for the procedure with the lesser value.

10. Arterial Perfusion/Axillary, Inguinofemoral or Pelvic Lymphadenectomy.

When arterial perfusion of an extremity for the treatment of malignant disease is performed in conjunction with an axillary, inguinofemoral or pelvic lymphadenectomy (superficial or radial) the arterial perfusion will be reimbursed at 100% of the allowance in addition to the lymphadenectomy.

11. Exchange Transfusions.

Exchange transfusions (36450-36455) are covered services. Reimbursement will be 100% of the allowance for all medically necessary transfusions.

12. Postoperative Complications Following Cardiovascular Surgery.

a. Treatment of postoperative complications following cardiovascular

-Continued-

procedures during the same hospital admission, requiring additional surgical procedures, are covered.

b. Reimbursement will be 50% of the allowance for the first complication and 25% of the allowance for each additional procedure, excluding hemorrhaging or wound dehiscence within 72 hours after the primary surgery.

13. Arteriogram Performed at Surgery.

When an arteriogram is performed at the operating table after an endarterectomy has been completed, to determine the result of the surgical procedure, no additional payment will be allowed for the arteriogram (injection procedure only); however, payment will be allowed for the radiological service (i.e., aortography and/or angiography).

14. Angiocardiography.

The full allowable charge for angiocardiography is payable to the primary provider. Additional or split payment will not be made to another physician for interpretation which duplicates an interpretation made by the primary provider, unless the primary provider requests a consultation.

15. Angistat (Carotid Sinus Nerve Stimulator.

a. Payment will be allowed for a carotid sinus nerve stimulator (Angistat) and for the related services required for the implantation of the device, for the relief of angina pectoris in carefully selected patients who are refractory to medical therapy and who, after undergoing

-Continued-

coronary angiography study, either are poor candidates for, or refuse to have coronary bypass surgery.

b. The use of the Angistat in the treatment of paroxysmal supraventricular tachycardia is considered investigational and, therefore, is not covered.

Subject: IMPLANTABLE INFUSION PUMP	Chapter: 3 Section: 5
Authority: DoD 6010.8 R, Chapter IV, D.l.	Page 36260.1.1
Approval: Deputy Director	Date February 26, 1986

PROCEDURE CODE RANGE	36260 36262
DESCRIPTION	The implantable infusion pump is surgically implanted into the subcutaneous tissue of the abdomen, and the delivery catheter is threaded into the appropriate vessel in order to provide long term continuous intravascular administration of drugs.
POLICY	The implantable infusion pump is considered appropriate for hepatic artery perfusion chemotherapy for the treatment of primary liver cancer or metastatic colorectal liver cancer where the metastases are limited to the liver.
EXCEPTIONS	1. The use of the implantable infusion pump for the treatment of thromboembolic disease is considered experimental and not covered at this time. 2. Other uses of the implanted infusion pump are currently under investigation and are still considered to be experimental at this time.
POLICY CONSIDERATIONS	The chemotherapeutic drugs used in conjunction with the pump must be FDA approved.

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Subject: THERAPEUTIC APHERESIS	Chapter: 3 Section: 5
Authority: DoD 6010.8-R, Chapter IV, D.1.	Page: 36520.1.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

* PROCEDURE CODE — 36520 *

* DESCRIPTION

Any procedure in which blood is withdrawn from a donor, a portion (plasma, leukocytes, platelets, etc.) is separated and retained, and the remainder is retransfused into the donor. *

* POLICY

Therapeutic apheresis is covered for the specific conditions outlined below. *

Myasthenia gravis during a life-threatening crisis;

Anti-basement membrane antibody nephritis (i.e., as a result of Goodpasture's Syndrome);

Life-threatening immune complex vasculitis;

Hyperviscosity of the blood associated with multiple myeloma, Waldenstrom's macroglobulinemia, and hypergammaglobulinemia purpura; and

Thrombotic thrombocytopenic purpura.

POLICY CONSIDERATIONS

Plasmapheresis should be used only after conventional forms of treatment have been tried and have proven ineffective in life-threatening situations only for those conditions listed above.

In some life-threatening situations, it may not be possible to have used conventional forms of treatment prior to the use of

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plasmapheresis. In these cases, conventional forms of treatment may be used in conjunction with plasmapheresis.

The use of plasmapheresis in the treatment of other than the conditions listed above is to be considered investigational.

The use of plasmapheresis in the treatment of any conditions prior to August, 1981, was considered investigational and not a CHAMPUS benefit.

Medical documentation must be submitted with the claim showing medical necessity for, and appropriateness of, the treatment.

All claims for the use of plasmapheresis in the treatment of the specified conditions shall be referred to medical review prior to processing. Claims for plasmapheresis involving treatment beyond ten exchanges must be reevaluated by FI medical review to determine whether the treatment continues to be appropriate for the particular patient.

Subject: HEMIC AND LYMPHATIC SYSTEMS	Chapter: 3 Section: 6
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 38090.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 38090 - 38999

DESCRIPTION

The lymphatic system involves the lymphatic vessels and lymphoid tissue, considered collectively. Hemic refers to the blood.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the hemic and lymphatic system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Splenectomy.

a. A splenectomy (38100) is a covered procedure when performed:

(1) As an independent procedure;

(2) In conjunction with other surgery, when the spleen is diseased or trauma has occurred prior to surgery, subject to multiple surgery guidelines.

b. A splenectomy necessitated by an injury occurring during abdominal or retroperitoneal operative procedures is not covered when performed by the same surgeon. A splenectomy performed by a physician other than the primary surgeon may be processed routinely.

Subject: BONE MARROW TRANSPLANTS	Chapter: 3 Section: 6
Authority: DoD 6010.8-R, E.5. *	Page: 38230.1.1 *
Approval: Deputy Director	Date: November 1, 1983

* **PROCEDURE CODE:** 38230 - 38240 *

DESCRIPTION

Allogeneic bone marrow transplantation is the aspiration of marrow from a donor and intravenous infusion of the marrow into a recipient.

POLICY

Allogeneic bone marrow transplantation is an authorized therapeutic measure for treatment of the following:

1. Aplastic anemia.

2. Acute leukemia.

3. Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies.

4. Wiskott-Aldrich syndrome.

5. Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease).

EXCEPTIONS

1. Benefits will not be provided for bone marrow transplantation for the treatment of the following:

   a. Thalassemia and other genetic disorders.

   b. Sickle cell anemia and other abnormal hemoglobin states.

   c. Polycythemia vera.

   d. Neuroblastoma.

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2. Autogenous (autologous) bone marrow transplantations (within the same individual) are considered experimental or investigational and therefore excluded for coverage.

* POLICY CONSIDERATIONS *

1. See Chapter 6, Part 1 of the COM-FI * for information concerning demonstrations.*

2. Recipient and donor costs in connection with covered bone marrow transplants are payable as follows:

a. Recipient costs are payable when the recipient is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.

c. Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.

d. Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event donor costs are paid as a part of the beneficiary or recipient costs.)

e. Donor costs are also payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient is a CHAMPUS beneficiary. (Again, in such an event donor costs are paid as a part of the beneficiary or recipient costs.)

f. If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.

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g. Donor transportation costs are excluded whether or not the donor is a beneficiary.

Subject: MEDIASTINUM AND DIAPHRAGM	Chapter: 3 Section: 7
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 39000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	39000 - 39599
DESCRIPTION	The mediastinum involves the mass of tissues and organs separating the two lungs, between the sternum in front and the vertebral column behind, and from the thoracic inlet above to the diaphragm below. It contains the heart and its large vessels, the trachea, esophagus, thymus, lymph nodes, and other structures and tissues. The diaphragm involves the musculomembranous partition separating the abdominal and thoracic cavities, and serves as a major inspiratory muscle.
POLICY	Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving either the mediastinum and diaphragm are covered, subject to the provisions of DoD 6010.8-R.

Subject: ANTI-GASTROESOPHAGEAL REFLUX IMPLANTATION (ANGELCHIK PROSTHESIS)	Chapter: 3
	Section: 7
Authority: DoD 6010.8-R, Chapter IV, G.15.	Page: 39599.1.1
Approval: Keith W Carter Deputy Director	Date: April 11, 1984

PROCEDURE CODE	39599
DESCRIPTION	This is a method of surgical correction of a hiatal hernia. A device is implanted around the esophagus, under the diaphragm and above the stomach to prevent the movement of the stomach through the hiatus. It's referred to as the Heyer-Schulte Angelchik Anti-Reflux Prosthesis, Angelchik Anti-Reflux Prosthesis or anti-gastroesophagel reflux implantation.
POLICY	The anti-gastroesophageal reflux surgical correction is considered investigational and is not covered by CHAMPUS.

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Subject: DIGESTIVE SYSTEM	Chapter: 3 Section: 8
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 40490.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE

40490 - 49999

DESCRIPTION

The digestive system involves the organs associated with the ingestion, digestion, and absorption of food.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the digestive system are covered, subject to the provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Services Related to Obesity.

For coverage information see Chapter 3, Section 8, page 43844.1.1 of this Volume I.

2. Esophagoscopy.

a. When an esophagoscopy is performed in conjunction with a laryngoscopy (31505-31578) during the same surgical session, reimbursement will be 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

b. When an esophagoscopy (43200-43228) is performed in conjunction with a laryngoscopy (31505-31578) and a bronchoscopy (31620-31659) during the same surgical session, reimbursement will be for the esophagoscopy and bronchoscopy. The

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procedures will be reimbursed at 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

3. Esophagogastroscopy.

Esophagogastroscopy (43200-43228) is a covered service and includes an esophagoscopy (43200-43228) and a gastroscopy (43235-43272). If performed during the same surgical session, reimbursement will be for the procedure with the greater value only.

4. Esophagogastroduodenoscopy.

Esophagogastroduodenoscopy (43235-43264) is a covered service and includes an esophagoscopy (43200-43228), gastroscopy (43235-43272), and duodenoscopy (44360-44369). If performed during the same surgical session, reimbursement will be for the procedure with the greater value only.

5. Gastroscopy/Laryngoscopy.

When a gastroscopy is performed in conjunction with a laryngoscopy (31505-31513) during the same surgical session, reimbursement will be 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

6. Gastroscopy/Laryngoscopy/Bronchoscopy.

When a gastroscopy (43235-43272) is performed in conjunction with a laryngoscopy (31505-31513) and a bronchoscopy (31620-31659) during the same

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surgical session, only the gastroscopy and bronchoscopy will be reimbursed. Allow 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

7. Small Intestinal Endoscopy/Proctosigmoidoscopy.

Small intestinal endoscopy beyond the second portion of the duodenum is a covered service. When a small intestinal endoscopy is performed in conjunction with a proctosigmoidoscopy during the same surgical session, reimbursement will be 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

8. Small Intestinal Endoscopy/Colonoscopy.

When a small intestinal endoscopy beyond the second portion of the duodenum is performed in conjunction with colonoscopy (45355-45385) during the same surgical session, reimbursement will be 100% of the allowance for the procedure with the greater value and 50% of the allowance for the procedure with the lesser value.

9. Colonoscopy/Proctosigmoidoscopy or Anoscopy.

When a colonoscopy (45355-45385) is done in conjunction with a proctosigmoidoscopy (45300-45321) or an anoscopy (46600-46614) during the same surgical session, reimbursement will be for the procedure with the highest value only.

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10. Anoscopy.

Anoscopy (46600-46614) is a covered service. When performed in conjunction with other surgery, multiple surgery guidelines will apply.

11. Proctosigmoidoscopy/Anoscopy.

Proctosigmoidoscopy (45300-45321) is a covered service. When a proctosigmoidoscopy is performed in conjunction with an anoscopy (46600-46614) during the same surgical session, reimbursement will be for the procedure with the highest value only.

12. Peritoneoscopy.

Peritoneoscopy (49300-49303) is a covered service. When performed in conjunction with other surgery, multiple surgery guidelines will apply.

13. Cinematography of the Digestive Tract.

Claims for cinematography (cineradiography) of the digestive tract must be documented as to medical necessity and referred to Medical Review.

14. Tonsillectomy and/or Adenoidectomy.

a. Tonsillectomy (42820-42826) is a covered service.

b. When an adenoidectomy (42830-42836) is performed in conjunction with a tonsillectomy during the same surgical session, there will be no reimbursement for the adenoidectomy.

c. An adenoidectomy when performed as an independent procedure, is a covered service.

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d. Excision of a lingual tonsil (42870) is a covered service when performed as an independent procedure. When performed in conjunction with other related procedures, no additional payment may be made.

e. Excision of a tonsillar tag (42860) is a covered service when performed as an independent procedure.

15. Teflon Injection.

Teflon injection into the posterior pharyngeal wall to correct velopharyngeal insufficiency is a covered service.

16. Gastrostomy/Intra-Abdominal Surgery.

a. A gastrostomy (43830-43834) is a covered service when performed as an independent procedure.

b. When performed in conjunction with any major intra-abdominal surgery, (except gastric procedures), reimbursement will be at 100% of the allowance for the major procedure and 50% of the allowance for the gastrostomy.

17. Exploratory Laparotomy.

a. An exploratory laparotomy (exploratory celiotomy, 49000), retroperitoneal exploration (49010), enterolysis (lysis of adhesions, 44000-44005), and biopsy of intra-abdominal organs (43605, 45100, 48100) are covered services.

b. When done in conjunction with other intra-abdominal surgery, reimbursement will be for the surgery with highest value only.

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18. Hernia Repair.

a. Hernia repair with an incarcerated or strangulated bowel (49500-49640) is a covered service.

b. When a portion of the bowel is removed during the same surgical session, reimbursement will be 100% of the allowance for the procedure with the higher value and 50% of the allowance for the procedure with the lesser value.

c. Hernia mesh repair is a covered service. An additional allowance may be made for this type of hernia repair.

19. Appendectomy.

a. An appendectomy (44950-44960) is a covered service when performed as an independent procedure.

b. An appendectomy that is performed for an indicated purpose or disease in conjunction with the excision of a Meckel's diverticulum (44800) is a covered service. Reimbursement will be 100% of the allowance for the procedure with the highest value and 50% of the allowance for the procedure with the lesser value. No allowance will be made for an appendectomy performed incidental to any other intra-abdominal procedure.

20. Omentectomy.

An omentectomy (49255) is a covered service only when the omentum is diseased. The claim must be documented by operative report and referred to Medical Review.

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21. Complete Proctectomy/Colostomy or Cecostomy.

When a complete proctectomy (45110) is performed in conjunction with a colostomy (44320) or a cecostomy (44320), reimbursement will be for the procedure with the highest value only.

22. Suprapubic Cystotomy/Complete Proctectomy.

When a suprapubic cystotomy (51520) is performed in conjunction with a complete proctectomy (45110), reimbursement will be 100% of the allowance for the procedure with the higher value and 50% of the allowance for the procedure with the lesser value.

Subject: VESTIBULOPLASTY PROCEDURES (SURGERY ON GUMS AND JAWS)	Chapter: 3 Section: 8
Authority: DoD 6010.8-R, Chapter IV, E.10.	Page: 40840.1.1
Approval: Deputy Director	Date: April 11, 1984

PROCEDURE CODE RANGE	40840-40845
DESCRIPTION	The vestibuloplasty is a surgical procedure which increases the size of the denture-bearing area and the height of the residual alveolar ridge. The primary objective of the procedure is to prepare the mouth for dentures.
POLICY	A vestibuloplasty is not a benefit of CHAMPUS.

Revision No: Revision Date:

6010.47-M

Subject:
SURGERY FOR TONGUE-TIE (ANKYLOGLOSSIA)

Chapter: 3

Section: 8

Authority:
DOD 6010.8-R, Chapter IV, C.1., G.1. and G.15.

Page: 41010.1.1

Approval: Keith W Carter

Date: [illegible] 01 1983

PROCEDURE CODE RANGE	41010, 41115 and 41520
DESCRIPTION	Tongue tie (ankyloglossia) is a condition in which there is a greater than normal fusion of the forepart of the tongue with the floor of the mouth. The fusion may be partial or total. To release the tongue-tie, a surgical procedure is sometimes performed. The procedure may be referred to as a lingual frenectomy, frenulectomy, frenotomy or a frenoplasty.
POLICY	Surgery for tongue-tie is not covered except in cases where total or complete ankyloglossia is documented. There is considerable lack of objective data and disagreement regarding the need for surgery in cases of partial tongue-tie. The procedure for other than total tongue-tie is considered unnecessary, and of no medical value.
POLICY CONSIDERATIONS	Total or complete ankyloglossia is rare (2 cases in 10,000). If any provider appears to submit an excessive number of claims for this diagnosis, the claims should be flagged for prepayment medical review.

Revision: Revision Date:

Subject: SURGERY FOR MORBID OBESITY	CHapter: 3
	Section: 8
Authority: DOD 6010.8-R, Chapter IV	Page: 43844.1.1
Approval: Deputy Director	Date: November 9, 1982

PROCEDURE CODE RANGE 43844 - 43845

DESCRIPTION

Morbid obesity means the body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200 percent
* or more of ideal weight for height and *
bone structure according to the most current Metropolitan Life Table.

POLICY

1. The morbid obesity benefit is limited to the gastric bypass, gastric stapling or
* gastroplasty, to include vertical banded *
* gastroplasty. Benefits may be extended *
only when one of the following conditions is met:

a. The patient is 100 pounds over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalmic disorders and severe arthritis of the weight-bearing joints.

b. The patient is 200 percent or more
* of the ideal weight for height and bone *
structure. An associated medical condition is not required for this category.

-Continued-

c. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon will, in many cases, do a gastric bypass, gastric stapling or gastroplasty at the same time as the takedown to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition may not technically meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

2. CHAMPUS payment may not be made for nonsurgical treatment of obesity, morbid obesity, dietary control or weight reduction.

EFFECTIVE DATE

December 27, 1982

POLICY CONSIDERATIONS

1. Any claim related to surgical treatment of morbid obesity must include documentation which gives the patient's history and shows that the patient meets the criteria for morbid obesity. Each claim related to surgical treatment of morbid obesity will be medically reviewed to assure compliance with the Program's criteria. Where necessary, additional clinical documentation must be obtained.

2. Even though the beneficiary may meet the morbid obesity criteria, gastric procedures are usually contraindicated when any of the conditions listed below are present. Although cases in these groups should not be categorically excluded, the FI shall conduct a special review to ascertain that the surgery was medically

-Continued-

appropriate in view of the circumstances. If the documentation does not support the medical appropriateness of the surgery, the FI shall deny the claim.

a. The patient is older than 50 or younger than 18.

b. Renal failure.

c. Inflammatory bowel disease.

d. Pulmonary embolization.

e. Chronic alcoholism.

f. Active hepatitis.

g. Cirrhosis of the liver.

h. Organic brain syndrome.

i. Mental retardation.

j. Profound psychotic disturbance.

k. History of anorexia nervosa.

l. Malignant tumors.

m. Infection, particularly in the skin or elsewhere in the body.

n. Dental disease.

Subject: URINARY SYSTEM	Chapter: 3 Section: 9
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 50010.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 50010 - 53899

DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the urinary system are covered, subject to all applicable provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Ureteral Endoscopy.

a. Ureteral endoscopy (50951-50980) is covered when performed through an established ureterostomy.

b. If ureteral endoscopy is performed in conjunction with a cystourethroscopy (52000-52700), reimbursement will be 100% of the allowance for the procedure with the greater value.

2. Cystoscopy.

a. When a cystoscopy is necessarily a part of another procedure, no additional payment will be allowed for the cystoscopy.

b. A cystoscopy is necessarily a part of the following procedures:

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(1) Transurethral resection of the vesical neck, in a female or child (52500).

(2) Excision of a bladder diverticulum (52305).

(3) Excision of a bladder tumor (52234-52240).

(4) Transurethral surgery (52204-52700).

c. If a cystoscopy with ureteral catherization (52005) is performed with any of the above procedures, 50% of the value of the ureteral catheterization is payable in addition to the allowance for the major procedure.

3. Cystourethroscopy/Meatotomy.

The allowance for cystourethroscopy (52000-52010) includes a meatotomy (53020-53025).

4. Urethral Dilation/Cystourethroscopy.

When urethral dilation (53600-53665) is performed in conjunction with a cystourethroscopy (52000-52010), reimbursement is included in the basic allowance of the cystoscopy.

5. Urethral Dilation/Cystoscopy.

Urethral dilation (53600-53665), when performed in conjunction with a cystoscopy (52000-52010) for urethral stenosis or structure, is a covered service and reimbursement will be on the basis of a cystourethroscopy with calibration and/or dilation of urethral structure of stenosis (52281).

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6. Renal Function Tests.

Differential, qualitative and chemical renal function tests (Howard or Stamey) are covered procedures. Reimbursement includes a cystoscopy with ureteral catheterization (52005-52010).

7. Treatment of Female Urethral Syndrome.

Treatment of the female urethral syndrome (52285) is a covered procedure and reimbursement includes cystourethroscopy, urethral meatotomy, urethral dilation, internal urethorotomy, lysis of urethrovaginal septal febrosis, lateral incision of the vesical neck, fulguration of polyp(s) of the urethra, vesical neck and/or trigone.

8. Cystourethroscopy.

Cystourethroscopy with removal of a ureteral calculus (52320) or manipulation without removal of a ureteral calculus (52330) is a covered service.

9. Transurethral Resection of the Prostate.

A transurethral resection of the prostate (52601) includes reimbursement for:

(1) Vasectomy (55250).

(2) Meatotomy (53020-53025).

(3) Cystourethroscopy.

(4) Internal urethrotomy (52270-52276).

-Continued-

10. Implantable Urethral Sphincter.

a. The F. Bradley Scott and Kaufman implantable urethral sphincters are covered prosthetic devices for patients with urinary incontinence resulting from permanent anatomic and neurologic dysfunctions of the bladder.

b. The following devices used for the management of urinary incontinence are not covered:

(1) Peri-urethral Teflon injection.

(2) Silastic gel implant.

(3) Acrylic prosthesis (Berry prosthesis).

12. Instillation of Anticarcinogenic Agent.

Bladder instillation of an anticarcinogenic agent (51720) is a covered procedure. The cost of the drug may be reimbursed separately.

13. Cystometrogram/Urethral Dilation.

When a cystometrogram (51725-51726) is performed in conjunction with a urethral dilation (53600-53621), reimbursement is 100% of the allowance for the procedure with the highest value and 50% of the allowance for the procedure with the lower value.

14. Cystoscopy/Cystometrogram/Panendoscopy.

When a cystoscopy, cystometrogram, and panendoscopy are performed at one operative session, reimbursement will be 100% of the allowance for the cystoscopy and 50% of the

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allowance for the cystometrogram. No allowance will be made for the panendoscopy.

15. Uroflowmetric Evaluations.

a. Uroflowmetric evaluations (urodynamic flow studies) are covered when necessary for the diagnosis of neuro-muscular dysfunction of the lower urinary tract, neurologic disease, neurologic dysfunction of the bladder or urologic disease. The services must be performed by or under the direct supervision of a physician.

b. Covered urodynamic procedures are:

(1) Cystometrogram studies.

(2) Uroflowmetric studies.

(a) External measurements.

(b) Internal stream measurements.

(3) Urethral pressure profile studies - urethral closure pressure profile.

(4) Electromyographic studies.

(5) Voiding pressure studies - bladder voiding pressure.

Subject: LITHOTRIPSY	Chapter: 3 Section: 9
Authority: DoD 6010.8-R, Chapter IV, C.	Page: 50087.1.1
Approval: Deputy Director	Date: June 3, 1985

PROCEDURE CODE RANGE

50087 - Percutaneous lithotripsy
50093 - Extracorporeal shock wave lithotripsy (ESWL)

DESCRIPTION

Percutaneous lithotripsy (or nephrolithotomy) is done by ultrasound, or by electrohydraulic or mechanical means. A probe is inserted through an incision in the skin directly over the kidney and applied to the stone. A form of lithotripsy is then used to fragment the stone. Mechanical or electrohydraulic lithotripsy may be used as an alternative or adjunct to ultrasonic lithotripsy.

Extracorporeal shock wave lithotripsy (ESWL) is a non-invasive method of treating kidney stones using a device called a lithotriptor. The lithotriptor uses shock waves generated outside of the body to break up upper urinary tract stones; it focuses the shock waves specifically on stones under X-ray visualization, pulverizing them by repeated shocks.

POLICY

The following lithotripsy techniques for the treatment of kidney stones are covered.

1. Extracorporeal shock wave lithotripsy (ESWL) for use in the treatment of upper urinary tract stones.

2. Percutaneous lithotripsy (or nephrolithotomy) by ultrasound or by the related techniques of electrohydraulic or mechanical lithotripsy.

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Claims for either covered procedure listed shall be paid as billed.

EFFECTIVE DATE

March 15, 1985.

EXCEPTIONS

Transurethral ureteroscopic lithotripsy (transurethral nephrolithotomy) involves the insertion of an endoscope using an ascending approach through the urinary tract itself. The stone is then fragmented using either ultrasound or electrohydraulic techniques. Transurethral ureteroscopic lithotripsy for the treatment of upper urinary tract stones is considered experimental, and is not covered under CHAMPUS.

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Subject: BLADDER STIMULATORS	Chapter: 3 Section: 9
Authority: DOD 6010.8-R, Chapter IV, C.1., G.15.	Page: 53899.1.1
Approval: Deputy Director	Date: February 26, 1986

PROCEDURE CODE	53899
DESCRIPTION	Bladder stimulators are devices to induce emptying of the urinary bladder by using electrical current to force muscles of the bladder to contract. These devices are characterized by the implantation of electrodes in the wall of the bladder, the rectal cones, or the spinal cord and are commonly called bladder stimulators or pacemakers.
POLICY	The use of bladder stimulators including the spinal cord electrical stimulators, rectal electrical stimulators, and bladder wall stimulators is not covered. No payment can be made for these devices or their implantation.
POLICY CONSIDERATIONS	Because the issue of safety involving the initiation of infection, erosion, placement, and material selection has not been resolved, these devices are not in accordance with good medical practice and established standards of quality. Their use is considered to be investigational.

Revision No: Revision Date:

Subject: MALE GENITAL SYSTEM	Chapter: 3 Section: 10
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 54000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE

54000 - 55899

DESCRIPTION

The male genital system includes the male organs of reproduction.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the male genital system are covered, subject to all applicable provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Prostatectomy.

Perineal, suprapubic and retropubic prostatectomies (55801-55845) are covered procedures.

2. Vasotomy/Biopsy of Testis.

A vasotomy (55300) is a covered service. When a biopsy of the testis (54500-54506) is performed in conjunction with a vasotomy, reimbursement for the biopsy is included in the basic allowance for the vasotomy.

3. Vasectomy.

A vasectomy (55250), unilateral or bilateral, performed as an independent procedure is a covered service. (See Section 12, Page 56000.1.4 of this Chapter 3 for detailed policy concerning sterilization and birth control.)

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4. Office Visit - Prostatic Massage.

An office visit which includes a prostatic massage will be reimbursed as a "minimal exam, established patient" (90030).

5. Implantable Urethral Spincter.

(See Chapter 3, Section 9, Page 50010.1.4 of the this Volume I.)

EXCEPTIONS

1. Penile Implant.

Penile implant procedures (54400 - 54409) and related services for either psychological or organic impotence are not covered.

2. Testicular Prosthesis.

Surgical procedures and related services for insertion of a testicular prosthesis (54660-54661) are not covered.

3. Treatment of Sexual Dysfunction.

Services or supplies provided in connection with sexual dysfunctions or inadequacies are not covered. (See Chapter 1, Section 1, Page 1.3.1 of this Volume I.)

Subject: INTERSEX SURGERY	Chapter: 3 Section: 11
Authority: DoD 6010.8-R, Chapter IV, E.7 and G.29.	Page: 55970.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	55970 - 55980
DESCRIPTION	Intersex involves an individual who shows intermingling, in varying degrees, of the characters of each sex, including physical form, reproductive organs, and sexual behavior.
POLICY	All services and supplies directly and indirectly related to intersex surgery are excluded under CHAMPUS, except surgery performed on a child ten (10) years of age or under to correct sex gender confusion (i.e., ambiguous genitalia).

Revision No: Revision Date:

Subject: FEMALE GENITAL SYSTEM	Chapter: 3
	Section: 12
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 56000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE

56000 - 58999

DESCRIPTION

The female genital system includes the female organs of reproduction.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the female genital system are covered, subject to all applicable provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below.

POLICY CONSIDERATIONS

1. Biopsy of Perineum.

Biopsy of the perineum (56100) is a covered service as an independent procedure. When performed in conjunction with related procedures (56000-58285), reimbursement will be at 100% of the allowance for the procedure with the highest value only.

2. Biopsy of Vulva.

Biopsy of the vulva (56600) is a covered service as an independent procedure. When performed in conjunction with related surgical procedures (56400-58285) on the same day, reimbursement will be at 100% of the allowance for the highest value only.

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Revision No: Revision Date:

3. Colpoperineorrhaphy, Episiorrhaphy, Episioperioneorrhaphy.

Colpoperineorrhaphy, episiorrhaphy, and episioperineorrhaphy (57210) are covered procedures. When performed in conjunction with other surgical procedures via the vaginal approach (56000-58285) on the same day, reimbursement will be at 100% of the allowance for the procedure with the highest value only.

4. Dilation of Cervical Canal.

Dilation of the cervical canal (57800) is a covered independent procedure. When dilation of the cervical canal is performed in conjunction with surgical procedures via the vaginal approach (56400-58285) on the same day, reimbursement will be at 100% of the allowance for the procedure with the highest value only.

5. Dilatation and Curettage (D&C).

a. Dilatation and curettage (D&C) of the uterus or cervical stump (58120) is a covered service. When performed in conjunction with a vaginal or abdominal hysterectomy (58150, 58260-58285), vaginal or enterocele repair (57265-57270), reimbursement will be made for the hysterectomy/repair only.

b. When a D&C is performed in conjunction with a tubal ligation, reimbursement will be made for the procedure with the higher value only.

c. See Chapter 3, Section 12, pages 59105.1.1 - 59104.1.4 of this Volume One for policy on abortions.

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6. Treatment of Female Urethral Syndrome.

Treatment of the female urethral syndrome (52285) is a benefit. Reimbursement includes cystourethroscopy (52100); urethral meatotomy (53020-53021); urethral dilation (53660-53665); internal urethrotomy (52270); lysis of urethrovaginal septal fibrosis; lateral incision of the vesicle neck; and fulguration of polyp(s) of the urethra, vesicle neck and/or trigone (52212).

7. Hydrotubage.

a. Hydrotubage (58350) is a treatment modality for chronic pelvic inflammatory disease and chronic salpingitis and is covered.

b. Reimbursement for tubal insufflation (58320) rendered in conjunction with hydrotubage is included in the basic allowance for the hydrotubage.

8. Tests for Stress Incontinence.

The Marshall or Bonney Test examination for stress incontinence is a covered procedure.

9. Colposcopy.

Colposcopy (57452-57454) is a covered procedure. Reimbursement for use of the colposcope is included as part of the allowance for an office visit or biopsy (if performed).

10. Transsexual Surgery.

Transsexual surgery (55970-55980) is not a benefit, except under very limited circumstances (See Chapter 3, Section 11 of this Volume One).

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11. Sterilization and Birth Control.

a. Elective sterilization, female or male, is covered and may be performed on either an inpatient or outpatient basis. These procedures are:

(1) Transection of the fallopian tube (58600-58611).

(2) Tubal ligation (58600-58611).

(3) Salpingectomy (58700).

(4) Laparoscopy (58982).

(5) Ligation of the vas deferens (55450).

b. Hysterectomy (58150-58285) performed solely for purposes of sterilization in the absence of pathology is not covered.

c. Postpartum sterilization (all methods and all approaches) is a covered service.

d. A tubal ligation (58600-58611) and/or a salpingectomy (58700) performed during a cesarean section is considered to be included within the basic cost of the cesarean section (59500-59541).

e. A hysterectomy, when performed during a cesarean section (59560-59581), is allowed at 50% of the usual allowance charge for the hysterectomy.

f. Surgical insertion, removal and/or replacement of intrauterine devices (58300-58301) are covered. Measurement for (57170) and purchase of the contraceptive diaphragms is also payable.

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g. Prescription oral contraceptives are payable.

h. The following services and/or supplies are excluded from coverage.

(1) Prophylactics (condoms).

(2) Spermicidal foams, jellies, sprays, etc., not requiring a prescription.

(3) Reversal of a surgical sterilization procedure (male or female).

(4) Artificial insemination, including any costs related to donors and/or semen banks.

(5) In Vitro fertilization. (See Chapter 8, Section 14, Page 14.1.1 of this Volume I).

12. Fertility Testing.

Fertility tests are covered.

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6010.47-M

Subject: TUBAL LIGATION CHARGES	Chapter: 3 Section: 12
Authority: DoD 6010.8-R, Chapter IV.C.3.a	Page: 58600.1.1
Approval: Keith W Curtis Deputy Director	Date: January 23, 1984

PROCEDURE CODE RANGE	58600 - 58611
POLICY	If a tubal ligation is performed in conjunction with any other procedure requiring an abdominal incision,the tubal ligation is considered incidental and no additional allowance can be made. (Tubal ligation in connection with a cesarean section.) When a tubal ligation is performed in conjunction with a surgical procedure that does not involve an abdominal incision, fifty (50%) percent of the allowable charge for the procedure with the lower allowable charge will be allowed in addition to the full allowable charge for the major surgical procedure. (Tubal ligation in conjunction with a vaginal delivery, D&C, needle biopsy, etc.)

Revision No:	Revision Date:

Subject: ABORTIONS	Chapter: 3 Section: 12
Authority: Defense Appropriation Act, Fiscal Year 1982 and Subsequent Years	Page: 59105.1.1
Approval: Deputy Director	Date: April 19, 1983

PROCEDURE CODE RANGE	59105-59106 and 59840-59852
DESCRIPTION	Abortion, as used in this policy, means the voluntary termination of pregnancy prior to the period of expected viability of the fetus. A spontaneous, missed or threatened abortion or termination of an ectopic (tubal) pregnancy are not included within the term "abortion" as used herein.
POLICY	Payment for abortions is prohibited by law except where the life of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. To ensure compliance with the law, CHAMPUS payment may not be made for any condition other than those specifically identified herein. Requests for approval of claims for abortion services must be forwarded to OCHAMPUS, Benefit Authorization Branch, Aurora, Colorado 80045, for a determination of whether to pay or deny.
EFFECTIVE DATE	June 5, 1981, for beneficiaries of the Department of Health and Human Services (includes the Coast Guard, Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration). December 29, 1981 for beneficiaries of the Department of Defense (includes Army, Navy, Air Force and Marine Corps).

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POLICY CONSIDERATIONS

1. Life endangering conditions. Payment is limited to the following conditions which may result in a significant mortality risk should the pregnancy be continued:

a. Malignancies (e.g., leukemia, lymphoma) indicating that the patient requires treatment with chemotherapeutic agents.

b. Malignancies (e.g., carcinoma of the breast) influenced by placental hormones/estrogen.

c. Renal failure and/or nephritis.

d. Diabetes uncontrolled after an adequate therapeutic trial in a controlled environment.

e. Congestive heart failure, regardless of underlying heart disease (e.g., congenital, rheumatic, coronary, hypertensive).

f. Severe cardiac disease without congestive heart failure (e.g., Eisenmengers, tetralogy, coronary artery disease, cardiac myopathy, and acute rheumatic carditis).

g. Lung disease with pulmonary insufficiency that fails to respond to appropriate therapy.

h. Malignant hypertension (progressive, diastolic pressure, at least 120 mm Hg, with retinopathy).

i. Primary pulmonary hypertension.

j. Seizures uncontrolled with therapeutic blood levels of analeptics.

k. Severe myasthenia gravis (e.g., with respiratory embarrassment).

l. Crohn's disease or ulcerative colitis.

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2. Dilatation and curettage (D&C). The D&C procedure is performed to terminate a pregnancy or as surgical treatment for other gynecological conditions. Payment consideration for D&C claims shall be based upon the diagnosis provided on the claim form. If the diagnosis on the claim form for the D&C procedure is abortion, one of the life-endangering conditions listed above must be present before payment is authorized.

3. Spontaneous, missed or threatened abortion and ectopic pregnancy. Services which are medically necessary for a spontaneous, missed or threatened abortion or termination of an ectopic (tubal) pregnancy may continue to be cost-shared under CHAMPUS.

4. Fetal demise. The dead fetus syndrome (also referred to as missed labor) is the retention within the uterus of a dead fetus. The death is from natural causes and not intentionally brought on by human intervention. In three-quarters of the cases, labor will start within 2 weeks of fetal death. In the remaining cases, prolonged retention of the fetus may require induction of labor. Those services which are medically necessary because of the dead fetus syndrome may continue to be cost-shared under CHAMPUS. Documentation must accompany the claim which verifies that death was from other than human intervention.

5. Complications from a noncovered abortion. The general policy on complications from noncovered treatment applies, see Chapter 3, Section 1, Pages 1.1.1 - 1.1.4 of this Policy Manual.

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6. Birth control drugs or devices. CHAMPUS may continue to cost-share for services and supplies related to birth control such as intrauterine devices, diaphragms, prescription oral contraceptives and surgical sterilization (either male or female). Reversal of a surgical sterilization procedure, however, is not covered.

* 7. Abortion for fetal abnormality or *
* mental health reasons. Abortions performed *
* for suspected or confirmed fetal abnormality*
* or for mental health reasons (i.e., *
* threatened suicide) do not fall within the *
* exceptions permitted within the language of *
* the law. *

8. Procedural guidelines. Procedural guidelines contained in COM-FI, Part 2, Chapter 1, Section IV, K.6. (Abortion Services) are to be followed in claims review processing.

Subject: NATURAL CHILDBIRTH *	Chapter: 3 Section: 13 *
Authority: DoD 6010.8-R, Chapter IV.G.44 *	Page: 13.1.1 *
Approval: Robert D Seaman for Director	Date: January 23, 1984

DESCRIPTION

Natural childbirth methods include:

1. Lamaze Method - Expectant mother and coach attend a series of classes to learn special breathing and relaxation techniques to manage labor and childbirth.

2. LeBoyer Method - Involves the complete avoidance of anesthetics and utilizes several special procedures during the delivery itself--a warm, dark delivery room; umbilical cord left in tact for some time, warm water bath for the infant.

POLICY

Charges for natural childbirth classes are not covered because they involve educational services rather than medical treatment.

Hospital costs associated with Lamaze patients, the LeBoyer method, or other alternate birth arrangements are usually built into its standard maternity charges. If there are hospital costs associated with an alternate birth arrangement due to the use of special equipment or services, such charges can be covered if the costs are reasonable considering the extent of services provided.

Alternate birth arrangements may include early discharge of mother and baby, usually about 12 hours after delivery. Such early discharge arrangements for maternity cases will be considered to be inpatient care even though the total time in the hospital is less than 24 hours.

Revision No: 1 Revision Date: August 26, 1985

Subject: MATERNITY CARE AND DELIVERY	Chapter: 3 Section: 13
Authority: DoD 6010.8-R, Chapter IV, C.2.1 and C.3.k.	Page: 59000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	59000 - 59899
DESCRIPTION	Maternity care is the care and treatment related to delivery, prenatal and postnatal care (generally through the sixth post-delivery week), and treatment of complications of pregnancy.
POLICY	Care and treatment related to delivery, prenatal and postnatal care, and complications of pregnancy, are covered, subject to all applicable provisions of DoD 6010.8-R.

Subject: FETAL MONITORING *	Chapter: 3 Section: 13 *
Authority: DoD 6010.8-R, Chapter IV, C.2.1.	Page: 59020.1.1
Approval: Robert D Seaman for Director	Date: April 19, 1983

PROCEDURE CODE RANGE 59020, 59025 and 59050

DESCRIPTION

Evaluation of the state of the fetus by an electronic detecting and recording device to define intrauterine condition. This policy covers three types:

1. 59020 - Oxytocin challenge test - (otherwise known as contractions stress test) - This test assesses the respiratory reserve of the fetus. Oxytocin is administered in amounts to produce 3 contractions within a 10-minute interval. The fetal heart rate and uterine contractions are recorded using an external electronic fetal monitor.

2. 59025 - Non-stress testing - Gross evaluation of the uteroplacental-fetal reserve. Requires simultaneous monitoring of fetal heart rate and fetal movements. Usually performed after 32 weeks.

3. 59050 - Internal fetal monitoring - Invasive method of monitoring performed during labor which records the fetal heart rate by an electrode placed transvaginally onto the fetus.

POLICY

1. Oxytocin challenge test: Separate payment (over and above the global maternity fee) may be made for the oxytocin challenge test for the indications listed below.

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The test is clinically appropriate only after the 28th week. A condition that does not appear on this list must be sent to medical review to ascertain if the test was medically appropriate in view of the circumstances. If the documentation does not support the medical appropriateness of the test, deny the claim.

a. Diabetes.

b. Chronic hypertension.

c. Hypertensive states of pregnancy.

d. Intrauterine growth retardation.

e. Sickle cell and related diseases, to including thalassemia and maternal hemoglobinopathy.

f. Maternal cyanotic heart disease.

g. Postmaturity.

h. A history of previous stillbirth.

i. RH isoimmunization.

j. Meconium-stained amniotic fluid by amniocentesis.

k. Preeclampsia.

l. Chronic renal disease with decreased function.

m. Chronic pulmonary insufficiency.

n. Systemic lupus.

2. Non-stress testing. Non-stress testing is considered as part of the overall maternity care/service, and must be included within the global charge.

-Continued-

3. Internal and external fetal monitoring: Charges for fetal monitoring (whether internal or external) must be included within the global charge for the maternity care episode.

EXCEPTIONS

This issuance only pertains to professional services. Payment should continue to be made to the institution for charges related to the fetal monitoring equipment.

POLICY CONSIDERATIONS

The oxytocin challenge test is usually contraindicated when any of the conditions listed below are present. Although cases in these groups should not be categorically excluded, a special review is required to ascertain if the test was medically appropriate in view of the circumstances. If the documentation does not support the medical appropriateness of the test, the claim shall be denied.

1. Premature rupture of the membranes.
2. Placenta previa.
3. Incompetency of the cervix.
4. Previous classic Cesarean section.
5. Multiple gestation.

Subject: ENDOCRINE SYSTEM	Chapter: 3 Section: 14
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 60000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	60000 - 60699
DESCRIPTION	The endocrine system consists of glands and other structures that elaborate internal secretions (hormones) which are released directly into the circulatory system and which influence metabolism and other body processes. Organs having endocrine function include the pituitary, thyroid, parathyroid, and adrenal glands, the pineal body, the gonads, the pancreas, and the paraganglia.
POLICY	Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the endocrine system are covered in accordance with the provisions of DoD Regulation 6010.8-R.

Revision No: Revision Date:

Subject: NERVOUS SYSTEM	Chapter: 3
	Section: 15
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 61000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE 61000 - 64999

DESCRIPTION

The nervous system consists of the central and peripheral nervous systems. The central is comprised of the brain and spinal cord and the peripheral includes all the other neural elements.

The nervous system is the organ system which along with the endocrine system, correlates the adjustments and reactions of an organism to internal and environmental conditions.

POLICY

Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the nervous system are covered in accordance with the provisions of DoD Regulation 6010.8-R.

Subject: CENTRAL NERVOUS SYSTEM STIMULATION
Chapter: 3
Section: 15
Authority: DoD 6010.8-R, Chapter IV, G.75.
Page: 61850.1.1
Approval: Deputy Director
Date: March 12, 1985

PROCEDURE CODE RANGE

61850 - 61888, 63650 - 63688

DESCRIPTION

1. Central nervous system is that portion of the nervous system consisting of the brain and spinal cord.

2. Deep brain (intracranial) stimulation is the electrical stimulation through implanted electrodes of specific regions of the deep brain i.e., thalamic and periaqueductal gray matter.

3. Spinal cord stimulation is the electrical stimulation through implanted electrodes of specific regions of the spinal column.

POLICY

Benefits are authorized for both spinal cord and deep brain stimulation in the treatment of chronic intractable pain.

EFFECTIVE DATE

December 1, 1979

EXCEPTIONS

Benefits will not be authorized for transcutaneous, percutaneous, functional dorsal column electrical stimulation in the treatment of multiple sclerosis or other motor function disorders. (See Chapter 8, Section 14 of this Volume One.)

POLICY CONSIDERATIONS

1. No payment may be made for the implantation of dorsal column or deep brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met.

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Revision No: 1
Revision Date: February 26, 1986

a. The treatment is used only as a late resort (if not a last resort) for patients with chronic intractable pain.

b. With respect to paragraph a, above, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient.

c. Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation.

d. Demonstration of the effectiveness of the treatment must be demonstrated with the use of a temporarily implanted electrode before implantation of a permanent electrode. If relief is not documented, implantation of a permanent device will not be authorized.

2. All claims must have documentation of having met the criteria outlined in paragraphs a. - d. above and subjected to medical review before authorization of benefits will be allowed.

3. Benefits are also authorized for the following:

a. Accessories necessary for the effective functioning of the covered device.

b. Repair, adjustment, replacement and removal of the covered device and associated surgical costs.

Subject: FACET BLOCKS *	Chapter: 3 Section: 15 *
Authority: DoD 6010.8-R, Chapter IV, C.2.a., C.3.(2)	Page: 62278.1.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

PROCEDURE CODE 62278, 62289, 64999

DESCRIPTION

The spinal facet block is a diagnostic test and is also a treatment. Both an anesthetic agent and a steroid are injected into the facet joint. The anesthesia is used to eliminate the pain and the steroid acts as an anti-inflammatory agent. By using a facet block, it can be determined if a patient has a partially disrupted facet joint as opposed to a disc problem. This is often a one time procedure, but reinjection may be necessary if the problem returns.

POLICY

The spinal facet block is an accepted procedure in the diagnosis of a partially disrupted facet joint or when used to relieve pain and reduce the inflammation in the facet joint.

POLICY CONSIDERATIONS

Spinal facet block injection is covered when provided by a physician as a diagnostic procedure to determine if the patient has a partially disrupted facet joint or in the treatment of pain related to the facet joint.

If there are multiple injections on a single day or there is any question of over-utilization of the facet injections, the case should be referred to medical review. If more than one injection is approved by medical review, injections shall be paid according to multiple surgical procedures for unrelated conditions.

Subject: CHEMONUCLEOLYSIS *	Chapter: 3
	Section: 15 *
Authority: DoD 6010.8-R, Chapter IV, C.2.a.	Page: 62292.1.1
Approval: Robert D Seaman for Director	Date: October 12, 1984

PROCEDURE CODE	62292
DESCRIPTION	The dissolution of the nucleus pulposus of an intervertebral disk by injection of a chemolytic agent, e.g., the enzyme chymopapain; used especially in the treatment of herniation of a disk.
POLICY	Chemonucleolysis utilizing chymopapain is covered only for the treatment of patients with documented herniated lumbar intervertebral discs whose signs and symptoms have not responded to conservative therapy over an adequate period of time. Based on time, skill, and risk, chemonucleolysis will be paid at 50% of the prevailing fee for a laminectomy (63005).
EXCEPTIONS	Chemonucleolysis utilizing chymopapain in the treatment of herniated discs in areas other than the lumbar spine is not covered because efficaciousness and safety have not been shown in other spinal regions. Chemonucleolysis utilizing any similar substance, other than chymopapain, in any area of the spine is considered investigational and not covered.

Revision No: 2 Revision Date: August 26, 1985

Subject: RADIOFREQUENCY FACET RHIZOLYSIS *	Chapter: 3 Section: 15 *
Authority: DoD 6010.8-R, Chapter IV.C.2.a.	Page: 63600.1.1
Approval: Robert D Seeman for Director	Date: October 12, 1984

PROCEDURE CODE	63600
DESCRIPTION	A procedure used for the alleviation of chronic back pain including the use of a local anesthetic around the lumbar vertebral facets with subsequent electro-coagulation.
POLICY	Radiofrequency facet rhizolysis is a covered procedure.
POLICY CONSIDERATIONS	1. The radiofrequency facet rhizolysis is indicated for patients who: a. Have not had surgery for disc disease but who have chronic low back pain and are not candidates for surgery; and b. Those patients who have had previous surgery, but have persistent chronic low back pain. 2. Claims must include documentation that conservative management of low back pain has failed and that standard surgical treatment has been attempted or is medically contraindicated. All claims for this treatment require medical review prior to payment.

Revision No: 1 Revision Date: August 26, 1985

Subject: ELECTRICAL STIMULATION OF THE PERIPHERAL NERVE *	Chapter: 3 Section: 15 *
Authority: DoD 6010.8-R, Chapter IV, D.1.	Page: 64550.1.1
Approval: Robert D Seaman for Director	Date: March 12, 1985

PROCEDURE CODE RANGE

64550 - 64595

DESCRIPTION

Transcutaneous electrical nerve stimulation (TENS) is the electrical stimulation of the peripheral nerves from the surface of the skin.

Percutaneous electrical nerve stimulation (PENS) is the electrical stimulation of the peripheral nerves by a needle electrode inserted through the skin.

POLICY

Electrical stimulation of the peripheral nerves is covered, when medically necessary, for the treatment of chronic, severe and intractable pain when other methods of pain control have been unsuccessful.

POLICY CONSIDERATIONS

1. Transcutaneous Electrical Nerve Stimulation (TENS) Coverage guidelines are as follows:

a. During the diagnostic trial period of up to four (4) weeks, two (2) treatments a week may be allowed for instruction in the use of TENS and assessment of its effectiveness. Any visits required beyond four (4) weeks must be documented for medical necessity and the claims sent to medical review. One month's rental of the TENS device may be paid during the diagnostic trial period.

-Continued-

b. An initial office visit is covered in addition to the TENS treatment.

c. An established patient office visit for the same diagnosis will not be covered on the same day that the TENS treatment is given.

2. Percutaneous Electrical Nerve Stimulation (PENS) Coverage guidelines are as follows:

a. During a diagnostic trial period of up to four (4) weeks, two (2) procedures a week may be allowed. Any procedures required beyond four (4) weeks must be documented as to medical necessity and the claims and supporting information sent to medical review.

b. An initial office visit is convered in addition to the PENS procedure.

c. After the initial visit, an office visit for the same diagnosis will not be covered on the same day that the PENS procedure is performed.

d. If pain is effectively controlled by PENS, implantation of electrodes is warranted.

3. TENS and PENS units are considered durable medical equipment and subject to the provisions of Chapter 7, Section 3, pages 3.1.1 - 3.1.7 of Volume One and Chapter 3, Section 1, pages 1.1.1 - 1.1.3 of Volume Two of the Policy Manual.

4. Benefits may be extended for medically necessary follow-up visits to monitor the patient's medical status.

-Continued-

5. Once a patient has been taught how to employ transcutaneous and percutaneous stimulation, it can be used safely and effectively without direct physician supervision. Consequently, it is inappropriate for a patient to visit a physician or outpatient clinic on a continuing basis for treatment of pain with electrical nerve stimulation. Therefore, the transcutaneous and percutaneous treatments, rather than the diagnostic services, are excluded from coverage.

Subject: PSYCHOSURGERY *	Chapter: 3
	Section: 15 *
Authority: DoD 6010.8-R, Chapter IV.G.15	Page: 64999.1.1
Approval: Robert D Seaman for Director	Date: January 23, 1984

PROCEDURE CODE 64999

DESCRIPTION

"Psychosurgery means brain surgery on:

1. Normal brain tissue of an individual who does not suffer from any physical disease, for the purpose of changing or controlling the behavior or emotions of such individual; or

2. Diseased brain tissue of an individual, if the primary object of the performance of such surgery is to control, change or affect any behavior or emotional disturbance of such individual."

"Psychosurgery includes the implantation of electrodes, destruction of or direct stimulation of brain tissue by any means (e.g.,ultrasound, laser), and the direct application of substances to the brain, when the primary purpose of such interventions is to change or control behavior or emotions." (National Commission for the Protection of Human Subjects of Biomedical and BehavioralResearch)

POLICY

Psychosurgery is not in accordance with accepted professional medical standards and is not covered.

POLICY CONSIDERATIONS

Surgery for the relief of movement disorders, electroshock treatments, and surgery to interrupt the transmission of pain along sensory pathways is not considered psychosurgery.

Revision No: 1	Revision Date: August 26, 1985

Subject: EYE AND OCULAR ADNEXA	Chapter: 3 Section: 16
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 65091.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	65091 - 68899
DESCRIPTION	The eye is the organ of vision and the ocular adnexa are the appendages or adjunct parts, i.e., eyelids, lacrimal apparatus.
POLICY	Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the eye or ocular adnexa are covered, subject to all applicable provisions of DoD 6010.8-R and the provisions of the "Policy Considerations" section below. Ophthalmological surgical procedures are covered and reimbursed on a global fee concept. These procedures include ophthalmological examinations before or upon admission, the surgical procedure and the normal follow-up care (all services commonly resulting from or directly related to the procedure performed).
POLICY CONSIDERATIONS	1. Cataract Extraction. a. Cataract extraction (66830-66945, 66983-66984) is a covered service and includes definitive refraction and lens prescription. b. Reimbursement is made without regard to the method utilized to extract the lens.

-Continued-

Revision No: Revision Date:

2. Iridectomy/Glaucoma Surgery or Cataract Extraction.

The surgical procedure for glaucoma (66130-66170) and/or extraction of the lens (66830-66945) is covered and includes reimbursement for an iridectomy (66600-66635).

3. Discission of Lens Capsule.

Discission of the lens capsule (needling of the lens)(66800-66801) is covered only when performed as an independent procedure. When performed in conjunction with other procedures, the reimbursement for discission of the lens capsule is included in the reimbursement for the other procedure.

4. Destruction of Iris.

Destruction of the iris (66700-66770), all methods, is a covered service when performed as an independent procedure. When performed in conjunction with a sclerectomy for glaucoma, reimbursement is included in the allowance for the sclerectomy.

5. Sclerectomy.

A sclerectomy (66160) is covered when performed as an independent procedure. When performed in conjunction with cataract surgery, reimbursement is included in the basic fee for the cataract extraction.

6. Cauterization of Lesions.

Cauterization of lesions of the eye using silver nitrate is a covered service.

-Continued-

7. Vitrectomy.

A vitrectomy (67005-67036) is covered when performed as an independent procedure. When performed in conjunction with other procedures, the reimbursement for a vitrectomy is included in the reimbursement for the other procedure.

8. Retinal Coagulation.

a. Retinal coagulation is a covered service for retinal detachment, retinal holes, and diabetic retinopathy conditions or neovascular diseases of the retina.

b. Reimbursement for additional or subsequent procedures from this group within the prescribed follow-up period should be disallowed as included in the basic allowance of the original procedure.

c. Reimbursement for additional or subsequent procedures from this group after the follow-up period will be at 50% of the prevailing or the physician's customary allowance (whichever is lower, not to exceed the physician's charge).

d. The total allowed charges for additional or subsequent procedures performed within 6 months after the original procedure should not exceed twice the allowed charge for the original procedure.

9. Retinal Drawings.

Detailed retinal drawings are included in the reimbursement for treatment of retinal detachments.

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10. Injection into the Eye.

An injection into the eye is a covered service only when performed as an independent procedure.

11. Trabeculectomy.

A trabeculectomy (66170) is a covered service when performed as an independent procedure. When performed in conjunction with cataract and other ophthalmological procedures, the allowance is included in the reimbursement for the major surgery.

12. Repair of Retinal Detachment.

Repair of retinal detachment (67102-67112) is a covered service and reimbursement includes a canthotomy (67715) and canthoplasty (67950).

13. Insertion of Punctum Plug.

(See Chapter 3, Section 16, Page 68830.1.1 of this Volume I.)

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Subject: CORNEAL TRANSPLANTS *	Chapter: 3 Section: 16 *
Authority: DoD 6010.8-R, Chapter IV.E.5.	Page: 65710.1.1
Approval: Robert D Seaman for Director	Date: January 23, 1984

PROCEDURE CODE RANGE	65710 - 65750
POLICY	A corneal transplant is a covered surgical procedure when medically necessary and appropriate.
POLICY CONSIDERATIONS	Eye bank charges to the hospital or surgeon are covered when supported by an invoice and when the eye bank customarily imposes this charge for all its patients. Eye banks themselves are not CHAMPUS authorized providers; therefore, payment can only be made when the eye bank bills either the hospital or surgeon who in turn, bill the patient.

Subject: INTRAOCULAR LENS IMPLANTATION *	Chapter: 3 Section: 16 *
Authority: DoD 6010.8-R, Chapter IV, D.3.g.	Page: 66983.1.1
Approval: Robert D Seamon for Director	Date: October 7, 1982

PROCEDURE CODE RANGE	66983 - 66985
POLICY	Intraocular lens (IOL) implantation is covered by CHAMPUS when the the IOL is approved by the U. S. Food and Drug Administration or is subject to an investigational device exemption. (See Volume I, Chapter 7, Section 6 of this Policy Manual.)
EFFECTIVE DATE	June 1, 1977 Policy regarding specular microscopy, interferometry and kerometry tests is effective March 1, 1984.
POLICY CONSIDERATIONS	Cataract surgery is considered medically necessary and any cataract surgery associated with a primary intraocular lens implant is a CHAMPUS benefit whether the IOL is FDA approved or not. Implantation services may include preimplantation ultrasound (A-scan) eye measurement of one or both eyes. Specular microscopy, kerometry and interferometry tests are covered when done prior to cataract surgery alone or cataract surgery with an IOL implant.

Subject: RADIAL KERATOTOMY *	Chapter: 3
	Section: 16 *
Authority: DoD 6010.8-R, Chapter IV, G.15.	Page: 66999.1.1
Approval: Robert D Seaman for Director	Date: December 29, 1982

PROCEDURE CODE	66999
DESCRIPTION	Radial keratotomy is a surgical procedure used in the treatment of myopia (nearsightedness) in which sixteen (16) radial incisions are made into the corneal tissues.
POLICY	The radial keratotomy surgical procedure is classified as an investigational procedure; and therefore excluded as a CHAMPUS benefit.

Revision No: 1 Revision Date: August 26, 1985

Subject:
STRABISMUS SURGERY *

Chapter: 3

Section: 16 *

Authority:
DoD 6010.8-R, Chapter IV, E.8.a.(1), E.8.a., G.49.

Page:
67311.1.1

Approval: Robert D Seaman for Director

Date:
December 29, 1982

PROCEDURE CODE RANGE 67311 - 67332

DESCRIPTION

Strabismus is a deviation of the eye which the patient cannot overcome without medical or surgical intervention. It can be congenital, acquired (developmental) or can be caused by disease or injury. Onset of congenital strabismus is at birth and onset of the acquired strabismus is after 1 year (average, 2 1/2 years). Generally the divergent eye has not developed normal visual acuity.

Medical treatment is directed toward improvement of vision in the "lazy eye" by patching the eye, using eyeglasses or with orthoptics and visual therapy. Surgery is indicated when maximal improvement has been attained by medical methods.

Surgical correction of most eye deviations involves lengthening or shortening the extraorbital muscles of the eye, namely the medial and lateral rectus muscles. Many times a series of operations must be done. Surgery for strabismus is generally done early in the life of the afflicted individual to prevent diplopia (double vision) and eventual blindness in the "lazy" eye.

POLICY

Surgery to correct strabismus (whether congenital, acquired or caused by disease or injury) is covered by CHAMPUS.

-Continued-

Revision No: 2
Revision Date. August 26, 1985

Subject: STRABISMUS SURGERY

EXCEPTIONS

Medical treatments associated with the treatment of strabismus such as orthoptics or visual therapy are not covered.

Eyeglasses prescribed in the treatment of eye deviations are not covered.

Treatment of strabismus with the injection of botulinum toxin is considered investigational and not covered.

POLICY CONSIDERATIONS

Surgical correction of the following eye deviations are covered by CHAMPUS:

Esotropia-permanent deviation inward (crossed eyes).

Exotropia-permanent deviation outward (wall-eye).

Hypertropia-permanent upward deviation.

Hypotropia-permanent downward deviation.

Cyclotropia-permanent deviation around the anteroposterior axis.

Subsequent surgeries necessary for the complete correction of a strabismus condition are covered.

Eye examinations required in the diagnosis of strabismus are covered.

Subject: PUNCTUM PLUG *	Chapter: 3 Section: 16 *
Authority: DoD 6010.8-R, Chapter IV, C.2.a.	Page: 68830.1.1
Approval: Robert D Seaman for Director	Date: November 1, 1983

PROCEDURE CODE 68830

POLICY CHAMPUS benefits may be provided for services rendered in connection with insertion of a punctum plug when used in the treatment of "dry eye" conditions (keratitis sicca or kerato conjunctivitis sicca).

Revision No: 1 Revision Date: August 26, 1985

Subject: AUDITORY SYSTEM	Chapter: 3 Section: 17
Authority: DoD 6010.8-R, Chapter IV, C.2. and C.3.	Page: 69000.1.1
Approval: Robert D Seaman for Director	Date: August 26, 1985

PROCEDURE CODE RANGE	69000 - 69979
DESCRIPTION	The auditory system pertains to the sense of hearing.
POLICY	Medically necessary services and supplies required in the diagnosis and treatment of illness or injury involving the auditory system are covered in accordance with the provisions of DoD Regulation 6010.8-R.

Revision No: Revision Date:

Subject: OTOPLASTY	Chapter: 3 Section: 17
Authority: DoD 6010.8-R, Chapter IV, C.2. & E.8.	Page: 69300.1.1
Approval: Teresa Hawkes Director	Date: 10/22/85

PROCEDURE CODE RANGE

69300 - 69301

DESCRIPTION

Plastic surgery of the ear; the surgical correction of ear deformities and defects.

POLICY

Otoplasties are generally covered under CHAMPUS in accordance with the guidelines in Section 1, Page 1.2.1 of this Chapter 3.

POLICY CONSIDERATIONS

1. Claims for reimbursement of an otoplasty must include the following (See Section 1, Page 1.2.4, Paragraph 10.):

    a. Signed medical statement indicating the purpose and results of the corrective surgery.

    b. Operative report.

    c. Close range photographs, if available, clearly showing the defect prior to surgery.

2. Fiscal intermediaries are required to apply specific guidelines on all claims as outlined in Section 1, Page 1.2.6 of this Chapter 3.

CHAPTER 4

RADIOLOGY

CHAPTER 4 - RADIOLOGY

SECTION		PAGE
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3.	Diagnostic Ultrasound	76500.1
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Subject: Digital Subtraction Angiography (also known as Computed Digital Radiography)	Chapter: 4 Section: 1
Authority: DoD 6010.8-R, Chapter IV, C.2.i.	Page: 1.1.1
Approval: Keith W Curtis	Date: Oct 7, 1982

DESCRIPTION

Digital subtraction angiography is a new method of radiological imaging which allows imaging of the arterial system following the intravenous injection of contrast medium. A computer enhances the films that are produced. The procedure is less invasive and less costly than traditional angiography. The visual image is of a higher quality. In addition, the patient does not need to be hospitalized.

POLICY

Digitalized subtraction angiography may be covered when performed in clinical conditions where a standard angiography would be medically necessary.

EXCEPTIONS

This policy does not apply to coronary angiography.

Revision No:	Revision Date:

Subject: THERMOGRAPHY	Chapter: 4 Section: 1
Authority: DoD 6010.8-R, Chapter IV, G.15.	Page: 1.2.1
Approval: Deputy Director	Date: 12 Oct 84

DESCRIPTION

Thermography is a procedure which relies upon measurement of infrared radiation from the body for diagnostic purposes. It is used for pathology of the female breast, peripheral vascular disease, musculoskeletal injuries and for detecting cervical lesions. Thermography can include various types of the telethermographic infrared detector/imagers or heat sensitive cholesteric liquid crystal systems that are applied to the skin.

POLICY

All claims for thermography should be denied on the basis of its status as experimental/investigative.

Subject: DIAPHANOGRAPHY	Chapter: 4 Section: 1
Authority: DoD 6010.8-R, Chapter IV, G. 15.	Page: 1.3.1
Approval: Deputy Director	Date: 12Oct84

DESCRIPTION	Diaphanography is an imaging procedure performed for the detection and evaluation of breast disease. Images are created with light by translumination of the breast.
POLICY	All claims for this procedure should be denied, as diaphanography is considered an experimental/investigative procedure.

Revision No:
Revision Date:

Subject: COMPUTERIZED TOMOGRAPHY	Chapter: 4
	Section: 2
Authority: DoD 6010.8-R, Chapter IV. E. 14	Page: 70450.1.1
Approval: Deputy Director	Date: June 4, 1984

PROCEDURE CODE RANGE

70450-70492, 71250-71270, 72125-72132, *
72192-72194, 73200-73202, 73700-73702, *
74150-74170, 76360-76375 *

DESCRIPTION

Computerized tomography records attenuated x-ray transmissions through the body and, utilizing a mini-computer, reconstructs a graphic image of a tomographic "slice" of a body area with marked anatomical detail.

POLICY

Medically necesary CT scans of the head and body are covered when all of the following criteria are met:

1. The patient is referred for the diagnostic procedure by a physician; and

2. The CT scan procedure is consistent with the preliminary diagnosis or symptoms; and

3. Other noninvasive and less costly means of diagnosis have been attempted or are not appropriate; and

4. The CT scan equipment is licensed or registered by the appropriate State agency responsible for licensing or registering medical equipment which emits ionizing radiation; and

5. The CT scan equipment is operated under the general supervision of a physician; and

6. The results of the CT scan diagnostic procedure are interpreted by a physician.

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POLICY CONSIDERATIONS

1. General. Claims for CT scans must be carefully reviewed to determine that the CT scan was medically appropriate considering the patient's symptoms and preliminary diagnosis. If there is any question as to the appropriateness of a CT scan, the attending physician should be asked to document the medical necessity.

2. Primary diagnostic tool for some conditions. CT scans have become a primary diagnostic tool for many conditions and symptoms making other noninvasive and less costly means of diagnosis not appropriate. In those cases where a CT scan is an appropriate primary diagnostic tool it is not necessary to request information on the results of other noninvasive testing. CT scans may be considered a primary diagnostic modality for evaluation of the following:

a. Brain tumors

b. Brain hemorrhage

c. Severe head trauma

d. Undiagnosed coma in children

e. Progressive focal neurological signs in children

f. Megalocephaly

3. CT Scan in the Evaluation of Headaches. CT scan is not indicated in the evaluation of uncomplicated, minor headache when it presents as an isolated symptom. CT scan may be indicated in the following:

a. Evaluation of headache that is intractible, unresponsive to medical management, or has changed in character.

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b. Evaluation of headache when it is associated with neurological signs or symptoms, or abnormal laboratory findings.

c. In acute or chronic headache when it is associated with a history of prior trauma, prior malignancy or a significant family history of neurological disease which might be associated with structural causes for headache (e.g., neurofibromatosis, tuberous sclerosis).

4. CT Scan in the Evaluation of Cerebrovascular Disease. CT scan may be indicated in suspected cerebrovascular disease when uncertainty exists in the differential diagnosis of cerebral infarction, cerebral hemorrhage or cerebral ischemia.

5. CT Scan in the Evaluation of Dementia. CT scan may be indicated in patients with dementia that is associated with neurological signs or symptoms (e.g., loss of intellectual function) of recent onset or which follows a rapidly progressive course.

6. CT Scan in Evaluation of Newborn. If ultrasound is not available, CT scan may then be used as a primary diagnostic tool in evaluating intracranial disease prior to the closure of the anterior fontanel. CT scan frequently complements ultrasound in refining diagnosis or in defining some parenchymal diseases such as peripheral hemorrhages not seen on ultrasound. CT scan is indicated, after the fontanel has closed, in the evaluation of suspected intracranial disease in infants and children. (See Section 3, page 76500.1.1 of this Chapter for policy concerning ultrasound diagnostic procedures.)

-Continued-

7. CT Scan in the Pediatric Patient. CT scan may be indicated in a pediatric patient with significant pertinent historical, physical, neurological, or laboratory data indicating the presence of intracranial disease. Clinical conditions include the following:

a. Intracranial congenital abnormalities with or without associated somatic syndromes.

b. Disorders of growth and development.

c. Abnormalities of head size.

d. Mental retardation, seizures, head trauma, and chronic headaches, particularly when there are additional significant clinical findings.

8. Mobile Units. CT scans performed by mobile units are subject to the same coverage requirements applicable to scans performed by stationary units.

9. Not Necessary to Review on a Claim-by-Claim Basis. To monitor and enforce these criteria on a claim-by-claim basis is unrealistic. Fiscal intermediaries should look for utilization patterns over time on a post-payment basis.

EFFECTIVE DATE October 1, 1978

Subject: MAGNETIC RESONANCE IMAGING (MRI)	Chapter: 4 Section: 2
Authority: DoD 6010.8 R, Chapter IV, A, B and C.	Page: 70540.1.1
Approval: Deputy Director	Date March 7, 1986

PROCEDURE CODES 70540, 70551, 71550, 72140, 73220, 73720, 74181, 75552, 76400

DESCRIPTION

Magnetic resonance imaging (MRI), formerly also referred to as nuclear magnetic resonance (NMR), is a noninvasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. MRI uses radiofrequency radiation in the presence of a carefully controlled magnetic field to produce high quality cross-sectional images of the head and body in any plane. MRI has become a useful diagnostic imaging modality that is capable of demonstrating a wide variety of soft-tissue lesions with contrast resolution equal or superior to computerized tomography (CT) scanning in various parts of the body. Among the advantages of MRI are the absence of ionizing radiation and the ability to achieve high levels of tissue contrast resolution without injected iodinated contrast agents.

POLICY

Medically necessary and appropriate use of MRI on certain soft tissue structures for the purpose of detecting disruptive, neoplastic, degenerative or inflammatory lesions may be covered. Coverage is limited to MRI units which have received premarket approval by the Food and Drug Administration (FDA); and such units must be operated within the parameters specified by the approval. If the services which are less expensive than MRI can meet the patient's needs, then CHAMPUS may pay no

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more than the allowance for the less expensive service.

POLICY CONSIDERATIONS

1. General. Claims for MRI must be carefully reviewed to determine that the MRI was medically appropriate considering the patient's symptoms and preliminary diagnosis. Standard claims development procedures apply as needed. The fiscal intermediary must assure that the MRI unit being used has received the premarket approval by the FDA. If there is any question as to the need for MRI, the attending physician should be asked to document the medical necessity and appropriateness. Also, see paragraph 3 below.

2. Covered Clinical Applications. MRI is useful in examining the head, central nervous system, and spine. Multiple sclerosis can be diagnosed with MRI. The contents of the posterior fossa are visible with this imaging technique. The inherent tissue contrast resolution of MRI makes it an appropriate standard diagnostic modality for general neuroradiology. Although degeneration of intervertebral discs can be detected, the MRI is not generally the preferred modality for diagnosing disc herniation or prolapse. However, in some cases, especially when sensitivity to contrast agents exists and their use is contraindicated, MRI may be covered.

MRI can assist in the differential diagnosis of mediastinal and retroperitoneal masses including abnormalities of the large vessels such as aneurysms and dissection. When a clinical need exists to visualize the parenchyma of solid organs to detect anatomic disruption or neoplasia, this can be accomplished in

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the liver, urogenital system, adrenals, and pelvic organs without the use of contrast materials. MRI may also be used to detect and stage pelvic and retroperitoneal neoplasms, and to evaluate disorders of cancellous bone and soft tissues. It may also be used in the detection of pericardial thickening.

Primary and secondary bone neoplasms and aseptic necrosis can be detected at an early stage and monitored with MRI. Patients with metallic prostheses, especially of the hip, can be imaged in order to detect the early stages of infection of the bone to which the prosthesis is attached.

3. Documentation and Medical Review Requirements. Considering the patient's symptoms and preliminary diagnosis, claims for MRI of the posterior fossa (cerebellum and brain stem), high cervical cord (C1 through C3), and for demyelinating diseases of the white matter of the brain (for example, multiple sclerosis) may be paid without being subject to medical review. All other MRI claims will require the documentation of medical necessity and appropriateness and will be referred to the fiscal intermediary (FI) medical review staff for a determination under the guidelines provided in this Section. Also, any claims for both CT and MRI scans for the same body area for the same episode of care will require documentation of need and will be reviewed for medical appropriateness.

If the medical review determines that the services which are less expensive than MRI could have met the patient's needs (for example, a CT scan or certain nuclear medicine procedures), then CHAMPUS will pay

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no more than the allowance for the less expensive service. In such situations, FIs will still use the appropriate MRI procedure code but on CEOB they will use the message code "13" as provided in COM-FI, Part 2, Chapter 1, Section VI.G.3.d.(19)(c).

4. Contraindications. MRI is not covered when the following patient-specific contraindications are present. It is not covered for patients with cardiac pacemakers or with metallic clips on vascular aneurysms. MRI during a viable pregnancy is also contraindicated at this time. The danger inherent in bringing ferromagnetic materials within range of MRI units generally restricts the use of MRI for acutely ill patients requiring life support systems and monitoring devices which employ ferromagnetic materials. In addition, the long imaging time and the enclosed position of the patient may result in claustrophobia, making patients who have a history of claustrophobia unsuitable candidates for MRI procedures.

5. Investigational Uses. Several uses of MRI have been identified as investigational and are not covered. These include procedures involving gating devices, which are generally used on organs which are in motion, such as the heart or lungs, the use of paramagnetic contrast materials, the measurement of blood flow and spectroscopy. In addition, MRI is not suitable for the imaging of cortical bone and calcifications, nor for procedures involving spatial resolution of bone or calcifications. The use of surface RF coils, whether for sending or receiving RF signals , in conjunction with MRI procedures, is also considered investigational.

EFFECTIVE DATE November 22, 1985

Subject: CHEST X-RAYS	Chapter: 4
	Section: 2
Authority: DoD 6010.8-R, Chapter IV, B, C, G.1., G.38	Page: 71000.1.1
Approval: Deputy Director	Date: 12 Oct 84

PROCEDURE CODE RANGE 71000 - 71035

POLICY

Chest x-rays are not payable for the following:

1. Routine prenatal chest x-rays for the detection of unsuspected disease.

2. Routine chest x-rays solely because of hospital admission, unless a patient is admitted for a surgical procedure which involves general anesthesia.

3. Routine chest x-rays for employment.

4. Repeated chest x-rays upon long-term facility admission.

5. Repeated chest x-rays of tuberculosis reactors, repeated chest x-rays of asymptomatic tuberculosis patients who have completed therapy and routine periodic chest x-rays during tuberculosis treatment.

6. Routine preplacement chest x-rays and periodic chest x-rays unrelated to job exposure.

Revision No: Revision Date:

Subject: UPPER GASTROINTESTINAL FLUOROSCOPIC STUDY	Chapter: 4 Section: 2
Authority: DoD 6010.8-R, Chapter IV, B and C	Page: 74240.1.1
Approval: Deputy Director	Date: nad 84

PROCEDURE CODE RANGE	74240 - 74247
DESCRIPTION	The upper gastrointestinal study is a fluoroscopic procedure performed for the detection and evaluation of diseases of the esophagus, stomach and duodenum. Single contrast images are created with barium sulfate contrast suspension. Double air contrast images are created with effervescent agents or the production of air.
POLICY	1. An upper gastrointestinal study is not indicated in the follow-up assessment of the asymptomatic patient treated for duodenal ulcer. 2. An upper gastrointestinal study is not indicated in the preoperative cholecystectomy patient unless symptoms suggest an upper gastrointestinal abnormality in addition to the documented cholelithiasis.

Subject: X-RAY PELVIMETRY IN MATERNITY CARE	Chapter: 4 Section: 2
Authority: DoD 6010.8-R, Chapter IV, B. & C.	Page: 74710.1.1
Approval: Deputy Director	Date: 11Oct84

PROCEDURE CODE	74710
DESCRIPTION	X-ray pelvimetry is a roentgenologic procedure that measures the dimensions of the maternal pelvis and fetal head prior to delivery.
POLICY	X-ray pelvimetry is seldom indicated in the management of pregnancy or labor and delivery. Charges for x-ray pelvimetry shall not be paid routinely. All claims for this diagnostic test shall be referred for review by the fiscal intermediary medical review department on a prepayment basis. Payment may be made only in the rare situation that the medical need for the procedure is considered justified based on the physician's statement of the patient's unique circumstances. The FI should be alert for patterns of excessive use.

Revision No: Revision Date:

Subject: PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY	Chapter: 4 Section: 2
Authority: DoD 6010.8-R, Chapter IV, B.2.r., C.2.m., and G.15.	Page: 75972.1.1
Approval: Keith W Carter	Date: Dec. 29, 1982

* PROCEDURE CODE RANGE 75972 - 75977 (93570 for coronary; angioplasty, single vessel) *

DESCRIPTION

This procedure involves inserting a balloon catheter into a narrow or occulded artery in order to canalize and dilate the artery by inflating the balloon.

POLICY

Percutaneous transluminal angioplasty in the treatment of arteriosclerotic obstructions in the lower extremities--i.e., the iliac, femoral, and popliteal arteries--is covered.

EXCEPTIONS

All percutaneous transluminal coronary angioplasites are considered investigational except when done on a single coronary artery. This procedure may be covered for treatment of stenotic lesions of a single coronary artery for patients for whom the likely alternative treatment is coronary bypass surgery, and who have the following characteristics:

Intractable angina inadequately controlled with maximal medical therapy;

objective evidence of myocardial ischemia; and

normal ventricular function.

Subject: X-RAY MAMMOGRAPHY	Chapter: 4 Section: 2
Authority: DoD 6010.8-R, Chapter IV, B. & C.	Page: 76090.1.1
Approval: Deputy Director	Date: 12 oct 84

PROCEDURE CODE RANGE 76090 - 76091

DESCRIPTION

X-ray mammography is a roentgenologic procedure performed for the evaluation and detection of breast disease. Images are created most commonly by one of two methods: screen film mammography and xeromammography.

POLICY

Mammography may be covered as a diagnostic procedure when a breast mass is found on physical examination or when signs or symptoms suggest possible malignancy.

Revision No:	Revision Date:

Subject: ULTRASOUND DIAGNOSTIC PROCEDURES	Chapter: 4 Section: 3
Authority: DoD 6010.8-R, Chapter IV, B. & C.	Page: 76500.1.1
Approval: Robert D Seaman for Director	Date: November 1, 1983

PROCEDURE CODE RANGE 76500 - 76999

DESCRIPTION

An ultrasound diagnostic procedure is the visualization of deep structures of the body by recording the reflections (echoes) of pulses of ultrasonic waves directed into the tissues.

POLICY

The use of the diagnostic ultrasound technique, which has been sufficiently developed and is considered essential to good patient care in diagnosing a wide variety of conditions, is covered.

EXCEPTIONS

Clinical reliability and efficacy have not been proven for the following ultrasound procedures, and related claims should be denied:

1. B-Scan for atherosclerotic narrowing of peripheral arteries (76925).

* 2. Monitoring of cardiac output (Doppler). (76632 and 93320) *

POLICY CONSIDERATIONS

1. Review for medical necessity. All claims for diagnostic ultrasound procedures will be reviewed to ensure medical necessity and approriateness for the diagnosis.

2. Routine diagnostic procedures. Claims for diagnostic ultrasound procedures for routine diagnostic procedures where other, more appropriate and less costly procedures

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would produce the same results, will be denied unless medical documentation substantiates the use of ultrasound.

3. Ultrasound in Maternity Care. Ultrasound is not routinely indicated in the management of pregnancy. Ultrasound may be indicated only if specific conditions exist. Specific indications for ultrasound include:

a. Increased risk factors (e.g., personal or family history of congenital anomalies).

b. High risk factors (e.g., maternal diabetes, malnutrition, alcohol or drug addiction).

c. Elderly primipara.

d. Uncertain gestational age prior to cesarian section only. (To determine gestational age when a cesarian section is not planned would not be covered.)

e. Suspected abnormalities of pregnancy, such as:

(1) Hydatidiform mole.

(2) Ectopic pregnancy.

(3) Threatened or missed abortion.

(4) Congenital malformations, fetal or maternal.

(5) Polyhydramnios.

(6) Placenta previa.

(7) Abruptio placenta.

(8) Vaginal bleeding.

-Continued-

f. Pre- and post-amniocentesis studies.

g. Suspected abnormal presentation of fetus.

h. Suspected multiple fetuses.

i. Suspected fetal demise.

j. Gynecologic or other pelvic mass.

k. Significant fetal growth abnormality as indicated by discrepancy between fetal size and estimated age. (This is a potential area for overuse. FIs should be alert for provider patterns where an ultrasound is done on all maternity patients with the broad justification to determine gestational age.)

4. Ultrasound for Breast Disease. Ultrasound is not routinely indicated in the primary evaluation of breast disease. It may be indicated under the following conditions when mammography is inconclusive:

a. Evaluation of the densely fibrous breast.

b. Following a positive mammography to distinguish a cyst from a solid lesion.

c. As a guide to needle aspiration to monitor cystic masses.

d. In the evaluation of a discrete breast mass in a young female.

5. Ultrasound in the Evaluation of Newborns. Ultrasound is appropriately used to evaluate the infant who is defined by clinical parameters as being at

-Continued-

high risk for intracranial bleeding, or who has a history of perinatal asphyxia, or who demonstrates significant neurological findings. Ultrasound is indicated prior to the closure of the anterior fontanel in the follow-up of intracranial abnormalities and of neurosurgical procedures. If ultrasound is not available, CT scan may then be used as a primary diagnostic tool in evaluating intracranial disease prior to the closure of the anterior fontanel. CT scan frequently complements ultrasound in refining diagnosis or in defining some parenchymal diseases such as peripheral hemorrhages not seen on ultrasound. CT scan is indicated, after the fontanel has closed, in the evaluation of suspected intracranial disease in infants and children. Ultrasound is indicated for the operative localization of brain abnormalities and operative guidance for biopsies and drainage procedures. Ultrasound may be performed as long as the anterior fontanel is open (up to 24 months).

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VOLUME 1

6010.47-M

Subject:
PROTON BEAM THERAPY FOR ARTERIOVENOUS MALFORMATION OF THE BRAIN

Chapter: 4

Section: 4

Authority:
DOD 6010.8-R, CHAPTER IV, B.2.j. and C.2.h.

Page:
4.1.1

Approval: Deputy Director

Date: February 26, 1986

DESCRIPTION

Arteriovenous malformations are considered congenital anomalies. The lesions become apparent clinically because they produce intracranial bleeding, seizures, headaches, progressive neurological deficits or other symptoms. Bleeding may produce severe neurological sequelae or death. There is general agreement that surgical excision is the preferred option if it can be done without great risk of a disabling neurologic deficit. This consists of surgical excision through craniotomy and embolization by pellets and tissue adhesives through angiographically positioned catheters. Some lesions, located in speech, motor or dominant hemispheric areas can not be treated conventionally. The size of the lesion and operative risk can also render patients untreatable by standard means (surgery or embolization). Bragg-peak proton beam treatment is considered for lesions unsuitable for these treatments. Proton beam therapy is a highly specialized form of treatment and only those centers with cyclotrons can make this therapy available.

POLICY

Proton beam therapy for arteriovenous malformations of the brain is payable when used as a last or only resort for arteriovenous malformation of the brain.

POLICY CONSIDERATIONS

1. All claims for this procedure will be subjected to medical review at the fiscal intermediary level.

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Subject: PROTON BEAM THERAPY FOR ARTERIOVENOUS MALFORMATIONS OF THE BRAIN

2. Documentation must substantiate that conventional therapy (craniotomy with excision or embolization) is unsuitable either because of the location, size or operative risk of the lesion.

Subject: RADIONUCLIDE IMAGING PROCEDURES	Chapter: 4
	Section: 5
Authority: DoD 6010.8-R, Chapter IV, B & C	Page: 78070.1.1
Approval: Deputy Director	Date: 12Oct84

PROCEDURE CODE RANGE 78070 - 78775

POLICY

Radionuclide imaging is covered when medically appropriate; however, the following procedures are seldom indicated and require special written justification:

78070 - Radionuclide parathyroid imaging - Computerized tomography (CT) is superior to radionuclide parathyroid imaging, including its use with selenium-75 selenomethionine.

78221 - Radionuclide liver function study with hepatobiliary agents, with probe technique - When available, computer-assisted radionuclide liver function study is superior.

78240 - Radionuclide pancreas imaging - Computerized tomography and ultrasound are superior to radionuclide pancreas imaging, including its use with selenium-75 selenomethionine.

78285 - Gastrointestinal fat absorption with radioiodinated triolein - Surpassed by other studies.

78704 - Radionuclide kidney imaging with function study (i.e., imaging renogram) - When available, computer-assisted renal scintigraphy study is superior to radionuclide kidney imaging with function study, including its use with I-131 hippuran and external scintillation probes.

CHAPTER 5

LABORATORY

CHAPTER 5 - PATHOLOGY AND LABORATORY SERVICES

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CHAPTER 6

INSTITUTIONAL

CHAPTER 6 - INSTITUTIONAL SERVICES

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2. Inpatient Admissions 2.1.1

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Subject: ADMISSION KITS	Chapter: 6 Section: 2
Authority: DoD 6010.8-R, Chapter IV, B.2.r.	Page: 2.1.1
Approval: Keith W Curtis	Date: Dec 29, 1982

DESCRIPTION	Hospital admission kits are normally provided to all patients upon admission and include such items as emesis basins, wash basins, pitchers, tumblers, mouth wash, soap, tooth brushes, tooth paste, combs, or lotions, etc.
POLICY	Hospital admission kits are covered.
POLICY CONSIDERATIONS	Charges shall be paid as billed for admission kit items whether billed separately or as a kit.

* * *

Individually billed items determined not to be customarily included in admission kits shall be denied unless determined to be otherwise medically necessary.

Revision No: Revision Date:

Subject: LATE DISCHARGE	Chapter: 6
	Section: 2
Authority: DoD 6010.8-R, Chapter IV.G.1.	Page: 2.2.1
Approval: Deputy Director	Date: January 23, 1984

DESCRIPTION	A late discharge represents a period of stay that is not medically necessary.
POLICY	Any costs associated with a late discharge are not covered whether or not the fault of the beneficiary.
* POLICY CONSIDERATIONS * *	When a hospital assesses late charges for a period of stay that is medically necessary, those costs can be covered.

Revision No: 1 Revision Date: October 12, 1984

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Subject: HOSPITAL SERVICES IN CONNECTION WITH NONCOVERED DENTAL CARE	Chapter: 6 Section: 2
Authority: DoD 6010.8-R, Chapter IV.E.10.e.	Page: 2.3.1
Approval: Deputy Director	Date: January 23, 1984

POLICY

Hospital services and supplies provided to a patient who requires a hospital setting for noncovered dental care due to a severe medical condition under active treatment is covered on both an inpatient and outpatient basis.

Professional services related to the noncovered dental care are not covered; professional services related to the medical condition (excluding the dentist and anesthesiologist) are covered.

POLICY CONSIDERATIONS

Preauthorization from the dental contractor is required. The preauthorization request must include:

1. A statement from the physician treating the medical condition documenting the seriousness of the medical condition and the reasons why a hospital setting is required.

2. An itemization of the specific dental procedures to be performed.

Covered services provided in connection with the noncovered dental services by the hospital outpatient department are cost-shared as outpatient care.

Revision No: Revision Date:

Subject: ANCILLARY INPATIENT MENTAL HEALTH SERVICES	Chapter: 6
	Section: 5
Authority: DoD 6010.8-R, Chapter IV, B.1.a., G.47., G.44, B.2.r., B.2.e., B.2.g., VII, B.2.j.	Page: 5.1.1
Approval:	Date: Dec 29, 1982

DESCRIPTION

Institutional providers of mental health services may bill one charge for all inpatient services or separately itemize all ancillary mental health services. These charges may be billed in addition to the room rate.

Customarily, individual and group therapy are the therapeutic services billed for, but the following kinds of additional therapies may be identified on inpatient mental health claims:

Social services group therapy
Counseling adapt group
Family therapy
Recreational therapy
Art therapy
Leisure time programs
Outings
Movies
Occupational therapy
Pharmacy
X-rays
Initial evaluations
Lab work

Most institutional facilities usually include only room and board and general nursing staff services in their room rate charge and itemize the other services when billing CHAMPUS.

POLICY

Charges for leisure time programs, outings and movies are not considered part of a

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CHAMPUS approved inpatient mental health therapy program.

Itemized mental health services, other than individual and group therapy, which are provided as an incidental part of an inpatient treatment plan may be covered by CHAMPUS. This would include miscellaneous ancillary therapy modalities such as recreational therapy, and art therapy.

Other therapy sessions such as family therapy, social services group therapy, adapt groups and occupational therapy may be covered when rendered as part of treatment related to an otherwise covered inpatient stay and when provided by a CHAMPUS authorized individual provider.

Initial evaluations are considered as other medical services and may be authorized. They must be directly related to the diagnosis and/or definitive set of symptoms and rendered by a member of the institution's medical and/or professional staff (either salaried or contractual) and billed for by the hospital.

Other ancillary services such as pharmacy, x-rays and laboratory charges are payable and customarily billed separately on the institutional claim form.

POLICY CONSIDERATIONS

Under Section C.3.i., Chapter IV of the Regulation, individual and group psychotherapy provided by a qualified professional (psychologist, psychiartist, etc.) is limited to no more than 5 one-hour therapy sessions in any seven day period.

Therapeutic programs or regimens, which may

-Continued-

include those services outlined in the policy section above, when provided by authorized individual providers who are employees of the institution, are not subject to the Regulation limitations for inpatient psychotherapy.

Subject: THERAPEUTIC ABSENCES	Chapter: 6 Section: 5
Authority: DoD 6010.8-R, Chapter IV, G.6.	Page: 5.2.1
Approval: Deputy Director	Date: 5 Dec 84

DESCRIPTION

A therapeutic absence in inpatient treatment of a mental disorder involves a patient's therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of from several hours to several days. The purpose of a therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge. Planned and clinically supported leaves are believed to contribute toward reducing the possibility of relapse and readmission.

POLICY

CHAMPUS will cover facility charges (room and board) during the period of a therapeutic absence only if the therapeutic absence is included in an approved treatment plan.

EFFECTIVE DATE

November 13, 1984

POLICY CONSIDERATIONS

1. The treatment plan submitted for the first review of an inpatient mental health admission should indicate the frequency and purpose of the leave. Therapeutic absences in RTC's will continue to be reviewed by OCHAMPUS. Therapeutic absences in other inpatient institutions will continue to be reviewed by the appropriate fiscal intermediary. Review will be for necessity and appropriateness relative to the goals of the treatment plan.

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Subject: THERAPEUTIC ABSENCES

2. The leave begins when the patient is signed out of the facility and ends when he or she is signed back in.

3. The facility retains control and responsibility for the patient during the therapeutic leave--the facility cannot fill the bed while the patient is away from the facility.

4. Charges, other than room and board (professional or ancillary), are excluded.

CHAPTER 7

OTHER SERVICES

CHAPTER 7 - OTHER SERVICES

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8. Home Oxygen and Oxygen Supplies 8.1.1

Subject: AMBULANCE SERVICE
Chapter: 7
Section: 2
Authority: DoD 6010.8-R, Chapter IV, D.3.e.
Page: 2.1.1
Approval: Deputy Director
Date: 25 Oct 84

DESCRIPTION

Transportation by means of a specifically designed vehicle for transporting the sick and injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such other safety and life saving equipment as is required by state and local law and is staffed by personnel trained to provide first aid treatment.

POLICY

Benefits should be provided for medically necessary ambulance services to, from and between hospitals utilizing the following guidelines:

1. Ambulance services must be medically necessary and reasonable. "Medical necessity" is established when the patient's condition is such that the use of any other method of transportation is contraindicated. The following conditions are presumed to meet this requirement:

a. Was transported in an emergency situation; e.g., as a result of accident, injury, or acute illness or

b. Needed to be restrained, or

c. Was unconscious or in shock, or

d. Required oxygen or other emergency treatment on the way to his or her destination, or

e. Was experiencing severe hemorrhage, or

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f. Had to remain immobile because of fracture that had not been set or the possibility of a fracture, or

g. Sustained an acute stroke or myocardial infarction, or

h. Was bed confined before and after the ambulance trip, or

i. Could be moved only by stretcher

In the absence of any of the above, additional documentation should be obtained to establish medical necessity.

2. Ambulance service is not covered when used in lieu of taxi services; i.e., to take the patient to the hospital for treatment or therapy when the use of an ambulance is not medically necessary enroute; or when the patient's condition would have permitted use of regular private transportation whether or not the private transportation was actually available.

3. Voluntary ambulances or such vehicles as medicabs and ambicabs do not qualify for benefits for the purpose of CHAMPUS.

> NOTE: The reference to voluntary ambulance is intended to mean the situation in which the organization that operates the vehicle does not issue a legally binding bill for services rendered but rather requests a contribution. If a legally binding bill is issued, it is not a "voluntary" ambulance for purposes of CHAMPUS even if manned (in whole or in part) by voluntary personnel.

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4. The patient must have been transported to the nearest institution with appropriate facilities for treatment of the injury or illness with the exception of transfers to a Uniformed Service Medical Treatment Facility (USMTF).

5. Ambulance coverage includes transfers to a USMTF from a beneficiary's place of residence, accident scene or other location, and transfers after treatment at, or admission to a civilian hospital. Payment would only be made when the ambulance is ordered by other than USMTF personnel.

6. Allowable charge/cost methodology will be used to adjudicate ambulance claims. Information from ambulance companies in each service area will be used in the development of prevailing base rate screens. In carrier service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on prevailing mileage charges may be allowed.

a. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance services and would be included in the cost of, or charge for, the trip.

b. A separate cost or separate reasonable charge based on actual quantities used may be recognized for nonreusable items and disposable supplies such as oxygen, gauze, dressings and disposable linens required in the care of the patient during his trip.

-Continued-

7. No separate benefit is allowed for services rendered by a paramedic, even when the service is of the type which is usually performed by a physician. Such services would include EKG monitoring, cardioversion, administration of drugs, obstetrical delivery, suturing of lacerations, etc. This exclusion applies even though the paramedic may be in direct telephone or radio contact with a licensed physician at the time the service is rendered.

8. Ambulance service by other than land vehicles (e.g., boat, airplane) may be considered only when the point of pick-up is inaccessible by a land vehicle, or great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

9. Under circumstances in which air ambulance services are approved, the patient's medical condition is frequently so unstable as to require a professional attendant to accompany the patient during the trip. The attendant is usually an RN or LPN but may occasionally be a licensed physician. The nurse or physician may be employed by or under contract to the air ambulance company or may be an independent practitioner. When services to a critically ill patient are rendered by a nurse or physician during the course of an approved air ambulance transfer, benefits may be extended subject to the following conditions:

a. The air ambulance transfer during which the professional services are rendered must itself be covered under the CHAMPUS

-Continued-

guidelines. If the air ambulance is not covered, the services of a medical attendant would not be covered.

b. The provider of service must be an authorized provider (physician, RN, LVN, LPN).

c. The claim must contain sufficient documentation to establish the medical necessity for the medical attendant's services.

d. The air ambulance company may include the professional attendant's services on its bill if the medical attendant is an employee of the ambulance company. In such circumstance, the cost of the medical attendant must be considered as included in the reasonable charge for the air ambulance.

e. The medical attendant who is an individual professional provider in his or her own right and who normally bills on a fee-for-service basis may do so for medical services rendered during an air ambulance transfer. However, Regulation requirements must be met. (For example: physician referral and supervision for services of an RN.)

f. Where an air ambulance company bills as an agent for a medical attendant, documentation must be provided before separate payment can be made.

10. Where land ambulance would have sufficed, the reasonable charge would be limited to the amount which would have been payable for a land

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ambulance if this amount is less than the air ambulance charge.

11. Ambulance transfers to a physician's office or clinic are not covered, even when certified as medically necessary by the attending physician. This includes situations where a hospital inpatient is transported to a physician's office or laboratory to receive a diagnostic service not available at the hospital and is immediately returned to the facility. CHAMPUS benefits for ambulance are limited (i.e., to, from and between hospitals only.)

EFFECTIVE DATE

October 23, 1984

EXCEPTIONS

Benefits should not be provided for ambulance service to a physician's office. However, when in the course of transporting a patient to a hospital the ambulance stops at a physician's office because of the necessity for professional attention and immediately thereafter continues the trip to the hospital, benefits should be provided.

A claim for ambulance service to a USMTF will not be denied on the grounds that there is a nearer civilian institution (hospital) having appropriate facilities to treat the patient.

POLICY CONSIDERATIONS

Ambulance service is not payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends or personal physician, with the exception of transfers to a USMTF.

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The following guidelines should be utilized in providing benefits for ambulance services to deceased members:

1. Benefits should not be provided when the member was pronounced dead by a legally authorized individual before the ambulance was called;

2. Benefits should be provided to point of pickup where the member was pronounced dead after the ambulance call, but before pickup;

3. Benefits for the entire ambulance service should be provided to a member who was pronounced dead while enroute to or upon arrival at the destination.

Regular monitoring of cost trends and abuses will be conducted by the Office of Program Integrity to assess program impact.

The CHAMPUS-approved procedures codes for payment of ambulance services may be found in the COM-FI(M), Part Three, Chapter 4, Addendum J, Table 8.

CHAMPUS POLICY MANUAL
VOLUME I

6010.47-M

Subject: DURABLE MEDICAL EQUIPMENT/BASIC PROGRAM	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter IV, D.3.b.	Page: 3.1.1
Approval: Keith W Curtis	Date: Dec 29, 1982

POLICY

Durable medical equipment (DME) is covered, provided such equipment meets the criteria outlined under policy considerations. (See COM-FI(M), Part Two, Chapter 4, Section I.C.10. for claims processing procedures.)

EFFECTIVE DATE

September 28, 1982

POLICY CONSIDERATIONS

1. Coverage criteria:

It must be medically necessary for the treatment of an illness or injury.

It must improve the function of a malformed, diseased or injured body part or retard further deterioration of the patient's physical condition.

It must be primarily and customarily used to serve a medical purpose, rather than primarily for transportation, comfort or convenience.

NOTE: A wheelchair (or Program-approved alternative) is not considered transportation in the sense of the above criteria. It is qualified as durable medical equipment under the provisions of the second policy consideration above, because by providing basic mobility, it retards further deterioration of the patient's physical

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Revision No: Revision Date:

condition. Mobility beyond that basic mobility provided by a wheelchair (or a Program-approved alternative) is considered to be primarily transportation.

It must withstand repeated use, and will be provided on a one-at-a-time basis only, based on the anticipated lifetime of the specific item of equipment.

It must be other than spectacles, eyeglasses, contact lenses or other optical devices and other than hearing aids or other communication devices.

It cannot be beyond the medically appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe). However this criterion is not intended to preclude the special fitting of equipment to accommodate a particular disability, such as fitting a wheelchair for a one-armed individual.

It cannot be for a patient in a facility which can provide or ordinarily provides such equipment.

It is not available for loan from any local Uniformed Service Medical Treatment Facility.

The allowable charge for the item must be more than $100.

2. Payment alternatives:

CHAMPUS reimbursement for DME is limited to the method which is most cost-advantageous to the Government. (See Volume II, Chapter 3, Section 1.)

-Continued-

3. Sales Tax:

Sales tax is authorized as part of the allowable charge.

4. Interest and Carrying Charges:

Interest and/or carrying charges added by a supplier to his charge for durable medical equipment purchased on an installment basis may be reimbursed on an allowable charge basis under specific conditions. (See Volume II, Chapter 3, Section 1.)

5. Delivery and Service Charges:

Delivery and service charges are authorized as part of the allowable charge. (See Volume II, Chapter 3, Section 1.)

6. Repair of DME owned by the beneficiary:

Repair of DME purchased by the beneficiary (either through CHAMPUS or other than CHAMPUS channels) may be cost-shared by CHAMPUS under the following criteria:

The repairs are limited to those required to make the equipment serviceable.

The physician states that the equipment continues to be medically necessary.

The cost of the repairs to make the equipment serviceable for the estimated period of need is less than the estimated

-Continued-

cost of rental, lease/purchase or outright purchase of a new unit.

The repairs are not necessitated by willful or malicious conduct on the part of the beneficiary.

Claims for repair must be sufficiently documented to make a determination of coverage in accordance with the above criteria.

Repairs to equipment not owned by the beneficiary will not be cost-shared by CHAMPUS.

Repair of rental equipment is the responsibility of the equipment supplier.

Equipment being leased/purchased by the beneficiary is considered to be rental equipment until the lease/purchase is completed and the beneficiary fully owns the equipment.

The cost of purchasing maintenance agreements will not be cost-shared by CHAMPUS.

7. Special Claim Documentation Requirements:

A copy of the physician's prescription for the item of DME must be submitted with the first DME claim. The prescription must contain the following information:

The patient's diagnosis (the medical necessity for the equipment).

-Continued-

What equipment is needed, any special features, and the medical necessity for such special features.

The estimated period of medical necessity.

The date the equipment was prescribed. (See COM-FI(M), Part Two, Chapter 4.)

8. Period of Medical Necessity:

In no case will rental payments be made beyond the period of medical necessity indicated in the physician's prescription without documentation of continuing need.

Prescriptions indicating an "indefinite" period of medical necessity will be clarified whenever possible to obtain a specific estimate. In most cases, once DME has been rented for a period of one or two months, the prescribing physician should be able to provide a more specific estimate. Initial prescriptions indicating an "indefinite" need will be recertified after a period of no more than three months, and at least every six months thereafter. "Lifetime" periods of medical necessity will automatically be considered for possible purchase or lease/purchase. Periodic verification of continued "lifetime" medical necessity will depend on the facts of the individual case. For example, a multiple amputee who requires a wheelchair will most likely have an ongoing and unchanging need for the chair. On the other hand, a recent single lower limb amputee who is to be fitted with a prosthesis may not need a chair

-Continued-

permanently, if the prosthesis is sucessfully fitted. Judgement must be exercised in the verification of continued need.

9. Notice to Beneficiary:

Once a determination on rental vs. purchase has been made, the beneficiary will be notified of that determination. (See COM-FI(M), Part Two, Chapter 4, Figure 4-2.)

10. Lease/Purchase:

If the beneficiary has entered into a lease/purchase agreement (usually to avoid a large one-time cost share) which is appropriate in light of anticipated medical necessity, a new claim will not be required every month. Payment can be made on an automatic monthly payment mechanism, with quarterly verification of eligibility (and of medical necessity, if appropriate). See COM-FI(M), Part Two, Chapter 4, page 4-22.)

11. Non-Cost-Advantageous Purchase:

In those instances where it can be established that medically necessary DME cannot be obtained via the most cost-advantageous method within a reasonable distance of the patient's residence, payment can be made on whatever basis is available as determined by the FI. This exception is meant to be applied only in extreme cases in which the FI has made a positive determination that the most cost-advantageous method is not available. (See Volume II, Chapter 3, Section 1.)

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12. Lump-Sum Payment for Outright Purchase:

When a determination is made that purchase of DME is cost advantageous, payment may be made based on the allowable charge for purchased DME in a lump sum with no specific dollar limit. (See Volume II, Chapter 3, Section 1.)

Subject: DURABLE EQUIPMENT/PFTH	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter V, H.2.b..	Page: 3.2.1
Approval: Deputy Director	Date: December 29, 1982

POLICY

Durable equipment is covered when the item of equipment is necessary in the treatment, habilitation, or rehabilitation of a handicapped beneficiary.

EXCEPTIONS

Durable equipment required by an institutional handicapped beneficiary must be provided by the institution as a part of the management plan and included in the monthly institutional charges. Only under extremely unusual situations (which would require individual review and consideration), could durable equipment be covered for an institutionalized beneficiary.

POLICY CONSIDERATIONS

1. In order to qualify as durable equipment, the item will be evaluated against the following criteria:

    a. It must be clearly related to and necessary for the habilitation, treatment, or training of beneficiaries with the given handicap.

    b. It must improve the function of a malformed body member or retard further deterioration of the handicapped beneficiary's physical condition.

    c. It cannot be useful to anyone in the absence of a physical or mental disability.

-Continued-

d. It must be primarily and customarily used to serve a medical or habilitative purpose rather than primarily for transportation, comfort or convenience.

NOTE: A wheelchair (or program-approved alternative) is not considered transportation in the sense of the above criteria. It is qualified as durable equipment under the second criteria above because by providing basic mobility, it retards further deterioration of the patient's physical condition. Mobility beyond that basic mobility provided by a wheelchair (or a program-approved alternative) is considered to be primarily transportation.

e. It cannot be beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe). However, this criteria is not intended to preclude special fitting of equipment to accommodate a particular disability (such as fitting a wheelchair for a one-armed individual.)

f. It is not available for loan from a local Uniformed Services medical treatment facility.

g. Durable equipment under the PFTH may be purchased or rented. However, because of the ordinarily long term need for the equipment under the PFTH, claims for rentals must be reviewed for cost effectiveness.

h. Only one similar item of durable equipment will be purchased during any one period of time. Benefits include repair of durable equipment purchased

-Continued-

under the PFTH and its subsequent replacement if it is determined that the previous item is no longer usable.

i. A physician must certify that the item of equipment is necessary in the treatment, habilitation, or rehabilitation of the handicapped beneficiary.

j. There must be written preauthorization by OCHAMPUS prior to the date of purchase of durable equipment. Such authorization is specific as to the item of durable equipment being approved. Further, such authorization is only valid for ninety (90) days from the date issued. If the item of durable equipment is not purchased within the time limit, a new preauthorization is required. Purchase of durable equipment may not be approved retroactively.

k. Benefits may also be extended for the reasonable charges for repair and replacement parts (such as batteries), including adjustment, of durable equipment purchased under the Program for the Handicapped. Such repair or part replacement or adjustment does not require preauthorization unless the charge is fifty dollars ($50.00) or more. In the case of an emergency, a charge above that amount may be considered without preauthorization, subject to special review.

l. Durable equipment will normally be cost-shared in the month that the purchase is made. However, where the equipment is a

-Continued-

high charge/cost item, the sponsor has the option of prorating the purchase price in equal monthly installments over a period not to exceed six months and beginning with the month of purchase. When the purchase price is prorated over several months, interest and carrying charges as well as delivery and service charges are allowable under the same conditions set forth in Volume II, Chapter 3, Section 3 of the Policy Manual. In no case shall payments be made by CHAMPUS beyond termination of eligibility as a CHAMPUS beneficiary. No other payment option is available.

Subject: ELECTRIC-POWERED, CART-TYPE VEHICLES	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter IV, D.b.	Page: 3.3.1
Approval:	Date: Dec 29, 1982

POLICY

Benefits may be extended for electric-powered, cart-type vehicles as an alternative to an electric wheelchair.

EFFECTIVE DATE

October 1, 1980

POLICY CONSIDERATIONS

Benefit determinations must be based on the following:

It is determined that the patient cannot, from a medical standpoint, use a standard, non-electric wheelchair; and

The physician has determined that this particular type of vehicle best meets the patient's medical needs.

Claims must be sufficiently documented to confirm that a proper evaluation of the patient's medical and physical condition has been made ascertaining that the patient requires such a vehicle and is capable of handling it safely.

Benefits will not be extended for the use of both an electric-powered, cart-type vehicle and an electric wheelchair during the same period of time.

Revision No: Revision Date:

Subject: "AT HOME" BLOOD GLUCOSE MONITORS	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter D.3.b.	Page: 3.4.1
Approval: Keith W Curtis	Date: Dec 29, 1982

POLICY

"At home" blood glucose monitors are covered for patients with the following diabetic conditions:

Insulin dependent diabetes with chronic renal failure or ongoing dialysis therapy.

Insulin dependent diabetes during pregnancy.

Insulin dependent diabetes with high renal threshold.

Brittle diabetes with documentation of episodes of insulin reaction or acidosis.

POLICY CONSIDERATIONS

Benefits are limited to patients with the above listed conditions only if they can achieve control by administering divided doses of insulin throughout the day.

Medical documentation must be submitted with the claim showing the medical necessity and appropriateness for the monitor.

Claims for conditions not shown above will be subject to medical review prior to payment.

For use in updating this policy, copies of claims paid for conditions not listed above, including the medical reviewer's rationale for authorizing payment, will be forwarded to the OCHAMPUS Policy Branch.

Subject:
SOUND OPERATED ELECTRICAL PATIENT CALL DEVICES

Chapter: 7

Section: 3

Authority:
DoD 6010.8-R, Chapter IV, D.3.b.(1)(f) and Chapter V, H.1 and H.2.b.

Page:
3.5.1

Approval: Keith W Curtis

Date:
Dec 29, 1982

DESCRIPTION

A sound operated electrical patient call device which enables patient's paralyzed from the neck down and unable to push a button to call for help.

POLICY

These devices do not qualify for benefits under the Basic Program or the Program for the Handicapped.

Revision No: Revision Date:

Subject: AQUA K CONTROL UNIT AND K PAD	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter IV.D.3.b. Chapter V.H.2.b.	Page: 3.6.1
Approval:	Date: APR 19 1983

DESCRIPTION	An Aqua K control unit and K pad provide continuous heat or cold therapy that can be thermostatically controlled to within one degree Fahrenheit.
POLICY	This equipment does not qualify for benefits under the Basic Program or the Program for the Handicapped because heat or cold therapy can be provided by the use of an ordinary heating pad or ice pack. The Aqua K unit does not meet the regulatory criterion that durable equipment "provides the medically appropriate level of performance and quality for the medical condition present (i.e., non-luxury, non-deluxe)".

Revision No: Revision Date:

Subject: PORTABLE PARAFFIN BATHS	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter IV.D.3.b. Chapter V.H.2.b.	Page: 3.7.1
Approval:	Date: APR 19 1983

DESCRIPTION	A portable unit used for paraffin heat therapy for arthritis.
POLICY	Benefits may be extended for these units under both the Basic Program and the Program for the Handicapped.
POLICY CONSIDERATIONS	Claims must be sufficiently documented to confirm that the patient has completed a successful trial period of paraffin heat therapy.

Revision No: Revision Date:

Subject:
ELECTRONIC CARDIO-RESPIRATORY HOME MONITORING EQUIPMENT (APNEA MONITORS)

Chapter: 7

Section: 3

Authority:
DoD 6010.8-R, Chapter IV.D.3.b.

Page:
3.8.1

Approval: Deputy Director

Date:
January 23, 1984

POLICY

Cardio-respiratory monitors for home use in the management of prolonged apnea are covered according to the following:

1. There must be a diagnosis of prolonged apnea by a physician. Prolonged apnea is defined as cessation of breathing for 20 seconds or longer or for less than 20 seconds when the apnea is associated with bradycardia, cyanosis, or pallor.

2. The monitor must be prescribed by a physician.

3. Documentation of the prolonged apnea must be included with the claim.

4. There must be certification by the physician that he or she will provide close continuing supervision.

Physician visits and diagnostic testing in connection with the monitoring are also covered.

POLICY CONSIDERATIONS

When a home monitor is required, the period of medical necessity is usually 3-6 months. When the monitor is in use for longer than 6 months, documentation of the medical necessity for continued monitoring by the attending physician is required.

Benefits can be provided for the rental, lease-purchase, or purchase as provided in Volume 1, Chapter 7, Section 3, pages 3.1.1 - 3.1.7 of this Policy Manual.

-Continued-

Subject: ELECTRONIC CARDIO-RESPIRATORY MONITORS

Chapter: 7 Section: 3 Page: 3.8.2

EXCEPTIONS

The following are not covered:

1. A back-up electrical system or any alteration to the living space which may be required to provide for such a system.

2. Parental training sessions, to include cardiopulmonary resusitation instruction and instruction in the use of the monitor. These charges should be included in the initial rental fee or purchase agreement.

3. Any charge for the availability of medical, technical or counseling assistance.

4. Equipment that monitors only respiration such as apnea mattresses or displacement pads.

5. Hospitalization in order to monitor a child with a history of prolonged apnea is not generally payable unless hospitalization is necessary to diagnose or treat underlying diseases or medical conditions which might be contributing to the apneic episodes.

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6010.47-M

Subject: PORTABLE INFUSION PUMPS	Chapter: 7 Section: 3
Authority: DoD 6010.8-R, Chapter IV, D.3.b.	Page: 3.10.1
Approval: for Maurice G. [illegible] Executive Officer Deputy Director	Date: June 4, 1984

DESCRIPTION

A small portable battery driven pump worn on the body (externally) and attached to a needle or catheter that provides continuous infusion of cancer chemotherapy agents, insulin, heparin antibiotics, or iron-chelating agents.

POLICY

Benefits are authorized for portable infusion pumps as durable medical equipment when utilized to administer the following:

1. Cancer chemotherapy agents

2. Deferoxamine

3. Insulin

    a. Only when the diagnosis is insulin dependent type I diabetes mellitus and there is documentation by the physician of poor diabetic control, such as:

        (1) Widely fluctuating blood sugar before mealtime

        (2) Frequent episodes of insulin reaction

        (3) Evidence of frequent significant ketosis

        (4) Insulin dependent type I diabetes mellitus complicated by pregnancy

EXCEPTIONS

1. Use of the portable infusion pump for the administration of heparin and

-Continued-

antibiotics is considered investigational and therefore, is not a benefit under CHAMPUS.

2. Implantable infusion pumps are considered investigational. See Chapter 8, Section 14, page 14.1.2 of this Volume One.

Subject: INSULIN INJECTORS WITHOUT A NEEDLE	Chapter: 7 Section: 4
Authority: DoD 6010.8-R, Chapter IV, D.3.c.	Page: 4.1.1
Approval:	Date: Dec 29, 1982

POLICY	Insulin injectors without a needle are covered provided medical documentation is submitted with the claim showing the medical need for the injector versus the ordinary syringe and needle. For example, the patient can no longer find an appropriate site for the injection.
POLICY CONSIDERATIONS	All claims for the device will receive medical review prior to payment.

Revision No: Revision Date:

Subject: TRANSCERVICAL BLOCK SILICONE PLUG	Chapter: 7 Section: 4
Authority: DoD 6010.8-R, Chapter IV, D.3.g.	Page: 4.2.1
Approval: Keith W Curtis	Date: [illegible]

DESCRIPTION	The transcervical block silicone plug is a device that is surgically secured in place in the fallopian tubes for sterilization of the female.
POLICY	This device is classified as investigational by the U.S. Food and Drug Administration and therefore excluded as a CHAMPUS benefit.

Revision No:	Revision Date:

Subject: SUPPORT HOSE	Chapter: 7 Section: 4
Authority: DoD 6010.8-R, Chapter IV, D.3.c.	Page: 4.3.1
Approval:	Date: NOV 01 1983

POLICY

1. Support hose are covered as a medical supply under the following circumstances:

a. Must be prescribed by a physician. A copy of the physician's prescription must be submitted with the claim.

b. Must be elastic surgical stockings made to support, bind, and maintain the muscles and tissues of the leg in position in a manner similar to that obtained through the use of a properly applied bandage of woven elastic material.

c. Their use must be directly related to an appropriate and verified covered medical condition for which benefits are otherwise authorized under CHAMPUS and are needed for the proper medical management of the condition.

2. Covered conditions include, but are not necessarily limited to, thrombophlebitis, edema and varicose veins, involving one or both legs.

Subject: BUTTON INFUSER	Chapter: 7 Section: 4
Authority: DoD 6010.8-R, Chapter IV, D.3.c.	Page: 4.4.1
Approval: Deputy Director	Date: February 26, 1986

DESCRIPTION

1. The button infuser is a semi-permanent subcutaneous needle, to which is connected a rubber stopper similar to those found on medication vials. A standard syringe needle is inserted into the stopper four times per day to deliver insulin. The subcutaneous needle is changed periodically, generally weekly.

2. The infuser was invented to minimize the number of needle insertions when four-times-daily insulin dosages are necessary for better control of blood glucose levels.

POLICY

Button infuser's are covered provided medical documentation is submitted with the claim showing the medical need for the infuser in addition to the ordinary syringe and needle.

Revision No:	Revision Date:

Subject: DIAPERS	Chapter: 7 Section: 4
Authority: DoD 6010.8-R, Chapter IV. G.1, & G.68	Page: 4.5.1
Approval: Deputy Director	Date: February 26, 1986

POLICY	Diapers, including both the disposable and cloth types, are not covered under the PFTH or the Basic Program.
POLICY CONSIDERATIONS	Diapers fall under the exclusion of comfort and convenience items. They are not medically necessary and would not directly contribute to the habilitation or rehabilitation of a dependent under the PFTH.

Revision No: Revision Date:

Subject:
ORTHOPEDIC BRACES AND APPLIANCES: SHOES

Chapter: 7

Section: 5

Authority:
DoD 6010.8-R, Chapter IV.D.3.h.

Page:
5.1.1

Approval: Deputy Director

Date:
January 23, 1984

POLICY

Orthopedic braces including shoes which are an integral part of the brace--neither the shoe nor the brace is usable separately--are covered.

POLICY CONSIDERATIONS

Shoes attached to orthopedic braces may be replaced when outgrown or worn out.

Impression castings necessary to construct a shoe that is an integral part of an orthopedic brace are also covered.

EXCEPTIONS

A separate shoe worn without a brace is not covered even if there is a foot deformity.

Revision No:

Revision Date:

Subject: PROSTHESIS REPLACEMENT	Chapter: 7 Section: 5
Authority: DoD 6010.8-R, Chapter V.H.2.h.	Page: 5.2.1
Approval: Deputy Director	Date: January 23, 1984

POLICY	Replacement of a prosthesis is covered when required due to growth or a change in the patient's condition.
POLICY CONSIDERATIONS	Preauthorization is required under the Program for the Handicapped. The claim or request for preauthorization should include the physician's prescription for replacement and the reason replacement is needed.

Revision No: Revision Date:

Subject: INTRAOCULAR LENSES	Chapter: 7 Section: 6
Authority: DoD 6010.8-R, Chapter IV, D.3.g.	Page: 6.1.1
Approval: Deputy Director	Date: Oct. 7, 1982

DESCRIPTION

Intraocular lenses (IOLs) are surgically implanted devices that replace the human lens of the eye.

POLICY

The following four categories of IOLs are covered:

1. Anterior chamber angle fixation lenses,
2. Iris fixation lenses,
3. Irido-capsular fixation lenses, and
4. Posterior chamber lenses.

EFFECTIVE DATE

June 1, 1977.

CHAMPUS POLICY MANUAL

Subject: Sonicguide and other such devices	Chapter: 7 Section: 6
Authority: DoD 6010.8-R, Chapter V,H.2.b.	Page: 6.2.1
Approval: Keith W Carter	Date: Oct 7, 1982

DESCRIPTION	The sonicguide is a device for visually handicapped individuals which operates on the principle of reflected high frequency sound which when converted into audible stereophonic signals provides the user with information about the distance, position and surface characteristics of objects within the travel path and immediate environment.
POLICY	These devices are authorized as durable equipment under the Program for the Handicapped.
EXCEPTIONS	These devices are not a benefit under the Basic Program.

Revision No:	Revision Date:

Subject: LENSES AND GLASSES	Chapter: 7 Section: 6
Authority: DoD 6010.8-R, Chapter IV.E.6.a.&b.	Page: 6.3.1
Approval: Deputy Director	Date: January 23, 1984

POLICY

1. A physician's prescription is required with all claims for covered lenses, both the initial lenses and any lenses required due to a change in the patient's condition.

2. Benefits for eyeglasses and lenses are generally excluded except in connection with the conditions specifically listed in the regulation. Benefits are also specifically limited to one set of lenses which includes those lenses and glasses necessary to restore vision. A set may include a combination of both contact lenses and lenses in frames when a combination is necessary to restore the vision.

POLICY CONSIDERATIONS

1. When there is a prescription change still related to the qualifying eye condition, a new set may be cost-shared after medical review.

2. When the prescription remains unchanged, replacement for lenses that are lost, have deteriorated or that have become unusable due to physical growth is not covered.

3. Adjustments, cleaning, or repairs of lenses and glasses are not covered.

Subject: DRUGS AND MEDICINES	Chapter: 7 Section: 7
Authority: DoD 6010.8-R, Chapter IV, C.2.c., D.3.f.	Page: 7.1.1
Approval: Deputy Director	Date: December 29, 1982

POLICY

Drugs and medications, whether administered by a physician or obtained by prescription, are covered when all of the following conditions are met:

1. The drug is medically necessary for the treatment of the condition for which it is administered, according to accepted standards of medical practice;

2. The drug is approved by the U.S. Food and Drug Administration for use in humans. (A drug that is approved for testing in humans is not covered.)

3. By law of the United States, the drug requires a physician's or dentist's prescription.

4. The drug is prescribed and dispensed in accordance with state law and licensing requirements;

5. The drug is not prescribed or furnished by a member of the patient's immediate family.

(For information concerning immunizations, see Chapter 1, Section 9 of this Volume.)

* (For more information concerning *
* processing of prescription drugs and *
* medicine claims, see the COM-FI, Chapter *
* 1, Part Two, Section V.C.7.f.) *

POLICY CONSIDERATIONS

1. The following policies apply to specific drugs:

-Continued-

a. ACTH (adrenocorticotropic hormone) is covered when used in the treatment of multiple sclerosis and rheumatoid arthritis. The drug is recommended for short-term administration during an acute episode or acute exacerbation. Claims involving long-term administration (over 30 days) shall be referred to medical review for determination of the appropriateness of the treatment.

b. Acutane, 13 cis-retinoic acid, is covered for the treatment of cystic acne.

c. Adrenal cortex extract injections are not covered.

d. Autogenous vaccines are not covered.

e. Autoplex, anti-inhibitor coagulant complex, is covered when administered to hemophiliacs who have developed antibodies to antihemophiliac factor. It is usually used in the treatment of massive bleeding or when surgery is necessary. All claims require medical review to determine that the drug was medically necessary and that other appropriate means of dealing with the situation were not available.

f. Calcimar injection is covered for Paget's disease of the bone and
* postmenopausal osteoporosis only. *

g. Calcium Disodium Edatate is covered only for the reduction of acute or chronic lead poisoning and lead encephalopathy.

h. Chymopapain is covered for the treatment of herniated lumbar intervertebral discs in accordance with FDA requirements. (See Chapter 3, Section 15, Page 62292.1.1 of this Volume One.)

-Continued-

i. Depo-Medrol used in the treatment of multiple sclerosis is not covered; it is considered to be investigational.

j. Disodium Edatate is considered investigational except in selected cases. See Chapter 1, Section 11, page 90784.1.1 of this Volume I.)

k. DMSO, dimethyl sulfoxide, is covered when used in the treatment of interstitial cystitis only.

l. Gamma globulin is covered only for the following biochemically confirmed conditions: hypogammaglobulinemia, agammaglobulinemia or dysgammaglobulinemia. Gamma globulin is not covered when administered as passive immunization after exposure to: measles, mumps, infectious hepatitis.

m. Human Chorionic Gonadatropin, or any other drug, administered for purposes of weight control is not covered.

n. Insulin is covered for diabetic patients, regardless of whether a prescription is required under state law.

o. Interferon is considered investigational for all diagnoses and is not covered.

p. Laetrile (amygdalin, Sarcarcinase, vitamin B-17 and nitriloside) and all other drugs called by the various terms mentioned above, or any other product which might be characterized as a "nitriloside", is not recognized to be safe and effective for any therapeutic use and is therefore not covered.

q. Placebo injections and drugs are not covered under any circumstances.

-Continued-

r. Potassium preparations ordered by a physician and obtained by prescription are covered when the medical necessity is documented and verified by medical review.

s. Sclerotherapy, the injection of sclerosing solution in the treatment of vericose veins and hemorrhoids, is an accepted procedure and may be cost-shared if medically necessary.

t. Vitamins are not generally covered under CHAMPUS. Oral vitamins, including those prescribed in the treatment of a specific vitamin deficiency and those related to prenatal care, are not covered.

u. Vitamin injections may be covered only if documentation is submitted showing that, according to generally accepted standards of medical practice, the vitamin is specific treatment for a diagnosed medical condition and that the patient is unable to take the vitamin preparation orally.

Subject: HOME OXYGEN AND OXYGEN SUPPLIES	Chapter: 7 Section: 8
Authority: DoD 6010.8-R, Chapter IV.D.3.d.	Page: 8.1.1
Approval: for Maurice [illegible], Executive Officer Deputy Director	Date: February 14, 1984

POLICY

Oxygen and equipment for its administration in the home are covered when the patient's ability to breathe is impaired to the degree that home oxygen is medically necessary.

Oxygen is limited to a 30 day supply and a tank unit at one location.

Repair and adjustment of CHAMPUS-purchased oxygen equipment is covered.

A portable oxygen system may be covered when necessary to complement the medical needs of a patient who requires a stationary system.

POLICY CONSIDERATIONS

Claims for oxygen must include a physician's prescription written within 30 days prior to the initial delivery of oxygen with the following information:

1. The patient's diagnosis which requires the use of oxygen;

2. Oxygen flow rate, frequency and duration of use;

3. Estimated length of time oxygen will be required;

4. Method of oxygen delivery.

The physician's prescription for a portable oxygen system must include the circumstances under which the portable system will be used, i.e., the medical purpose to be served by the portable oxygen which cannot be met by the stationary system.

-Continued-

Revision: Revision Date:

If the initial prescription shows an indefinite or lifetime need for oxygen, a new prescription is required annually.

Claims with an unusual amount of oxygen or deluxe equipment should be referred to the FI's medical review staff.

EXCEPTIONS

The following are not covered:

1. Spare oxygen supplies kept at a separate location.

2. Preset portable oxygen units are not covered. A preset unit is primarily designed and meant to be a first aid item and not for long-term therapy.

3. Regulators that permit a flow rate greater than 8 liters per minute are not appropriate and are therefore not covered.

4. Oxygen (95%) and carbon dioxide (5%) inhalation therapy for inner ear disease. The therapeutic benefit derived from this procedure is not established.

EFFECTIVE DATE

April 29,1980

CHAPTER 8

SPECIAL BENEFIT INFORMATION

CHAPTER 8 - SPECIAL BENEFIT INFORMATION

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CHAPTER 8 - SPECIAL BENEFIT INFORMATION (continued)

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Subject: Myofacial Pain Dysfunction Syndrome	Chapter: 8 Section: 1
Authority: DoD 6010.8-R, Chapter IV, E.10.	Page: 1.1.1
Approval: Keith W Carter	Date: APR 19 1983

DESCRIPTION

Myofacial pain dysfunction syndrome is also referred to as the temporomandibular joint syndrome. This is a condition in which a muscle spasm causes pain in or about the ears, muscle tiredness and slight soreness upon waking, as well as stiffness of the jaw.

POLICY

Treatment for stabilization of the condition to relieve pain is covered. Stabilization is limited to initial radiographs, up to four office visits and the construction of an occlusal splint, if necessary, to relieve pain and discomfort.

EXCEPTIONS

Occlusal equilibration and restorative occlusal rehabilitation are excluded. Any treatment beyond stabilization for the immediate relief of pain is excluded.

POLICY CONSIDERATIONS

1. Any repeat episodes of care within a six-month period must receive individual consideration and be documented by the provider of services.

2. Preauthorization is not required for the immediate treatment necessitated to stabilize the condition. Claims which fall within this category should be adjudicated by the dental fiscal intermediary.

Revision No:	Revision Date:

Subject: ORTHODONTIA RELATED TO SCOLIOSIS	Chapter: 8 Section: 1
Authority: DoD 6010.8-R, Chapter IV.E.10.b(5)	Page: 1.2.1
Approval: Keith W Cute Deputy Director	Date: January 23, 1984

POLICY

All orthodontia is excluded except when a necessary adjunct to the surgical correction of a congenital cleft palate.

Orthodontia related to the treatment of scoliosis with a Milwaukee Brace is not covered.

Revision No: Revision Date:

Subject: SUBSTANTIALLY BASIC PRODUCTIVE ACTIVITIES OF DAILY LIVING - CHAMPUS PROGRAM FOR THE HANDICAPPED (PFTH)
Chapter: 8
Section: 3
Authority: DoD 6010.8-R, Chapter V, E.1.b.
Page: 3.1.1
Approval: Keith W Carter
Date: NOV 01 1983

DESCRIPTION

Substantially basic productive activities of daily living include activities people are primarily engaged in day-in and day-out and vary according to the age group. Substantially basic productive activities for the age group 0-6 would involve school work, the process of socialization and similar play time activities. Activities for the age group 6-18 would involve formal learning, participation in school activities, increased responsibility for home chores, a higher degree of socialization and perhaps a part-time job.

POLICY

For individuals that meet the specific criteria set forth under the CHAMPUS Program for the Handicapped for mental retardation and the criteria for the physical handicapping conditions in Chapter V, E.2.a.-j., it can generally be assumed that basic productive activities of daily living have reached the point where the individual will require assistance that other people of that age without that handicap would not need. For individuals that meet the criteria in E.2.k.-2.p., Chapter V, a determination will need to be made on a case-by-case basis as to whether the medical documentation indicates that the individual is not functioning as independently as can generally be expected of an unimpaired person of that age group. In the medical statement accompanying the application for benefits, the beneficiary's attending physician should document in the "Statement of Dependent's Condition," any difficulty the individual is having in achieving a normal life style in the home, school and community environment.

-Continued-

POLICY CONSIDERATIONS

A. In evaluating the documentation, the reviewer (Benefit Authorization Branch, OCHAMPUS) should ask questions similar to the following to reach a conclusion as to whether the individual requires assistance that others in the same age group would not require:

1. DEVELOPMENTAL MILESTONES: Is there documentation which substantiates that the child is not meeting significant developmental milestones BECAUSE OF AN UNDERLYING PHYSICAL HANDICAPPING CONDITION OR MENTAL RETARDATION? NOTE: DEVELOPMENTAL DELAY, IN AND OF ITSELF, IS NOT TO BE CONSTRUED AS A HANDICAPPING CONDITION. The developmental delay must be correlated with substantial dysfunctions relative to unimpaired children. The recognized major areas of development for children include:

a. Physical-biological;

b. Psychological-emotional;

c. Social-interpersonal;

d. Cognitive-intellectual; and

e. Speech-language communication.

Adolescent and adult development would also emphasize academic-vocational capacities and capabilities.

2. SCHOOL. Is the child able to go to school? If so, are special arrangements required?

3. PERSONAL NEEDS. Is the individual able to attend to personal needs such as dressing, eating or using the toilet, commensurate with others of the same age?

-Continued-

4. PHYSICAL MOBILITY. Is the individual mobile? Does the individual need assistance ambulating? Does the individual need assistance using stairs? Is the individual capable of lifting? Is the individual capable of using public transportation unaided? Is the individual required to stay in the house most of the time? Is there any difficulty in reaching or in using their hands?

5. EQUIPMENT NEEDS. Is adaptive equipment essential for the individual because of the handicapping condition?

6. CUSTODIAN/AIDE. Is the individual (for older children) capable of normal activities without the presence of a custodian? Is the individual able to go outdoors without help from another person?

7. SENSORY LIMITATIONS. Is hearing, speaking or seeing significantly impaired?

B. EXAMPLES OF REQUESTS WHICH WOULD NOT QUALIFY FOR BENEFITS UNDER THE PFTH.

1. HYALINE MEMBRANE DISEASE. This disease is treated in the intensive care unit of the hospital and the patient is then discharged. No handicapping condition remains to the extent which would result in a positive response to any of the above questions. In fact, such infants have a good prognosis for neurologic and intellectual development. Thus, hyaline membrane disease, in and of itself--without substantial associated dysfunctions--would not be eligible for benefits under PFTH.

-Continued-

2. SPEECH DISORDERS. In and of themselves, speech disorders are not handicapping enough to permit eligibilty under the PFTH. For example, a child with a mild speech delay due to a developmental lag or impaired learning, might benefit from speech therapy but would not be eligible for the PFTH. On the other hand, a child with a documented brain, neurosensory or ear disease or injury which results in significant impediments in normal functions noted, could be considered seriously physically handicapped on the basis of the documented disease or injury causing the speech handicap.

3. ATTENTION DEFICIT DISORDERS. This new DSM-III category encompasses all the classifications of this disorder including hyperkinetic syndrome, minimal brain dsyfunction, minor cerebral dysfunction, and others. These are all specifically excluded by paragraph J.l., Chapter V. of the Regulation, unless secondarily related to moderate or severe mental retardation or a serious physical handicap.

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Subject: HEARING IMPAIRMENT CRITERIA - PROGRAM FOR THE HANDICAPPED	Chapter: 8 Section: 3
Authority: DoD 6010.8-R, Chapter V, Section E.2.c.	Page: 3.2.1
Approval:	Date: NOV 2 [illegible]

DESCRIPTION

The CHAMPUS Regulation, DoD 6010.8-R, is amended to replace existing hearing impairment criteria with that representative of current thinking on the handicapping effects of hearing impairments.

POLICY

Dependents of active duty members meeting the following criteria may be eligible for benefits under the Program for the Handicapped. Preauthorization is required.

1. Hearing Impairment: Testable Patients. A hearing impairment is a serious physical handicap when, unaided by amplification, it is manifested by:

a. A 45 decibel Hearing Threshold Level (HL) or poorer in either ear tested at 1,000; 2,000; or 3,000 Hz frequencies; or by

b. A 30 decibel HL or poorer in each ear tested at 1,000; 2,000; or 3,000 Hz frequencies; or by

c. Speech discrimination of 60% or poorer with either ear.

2. Hearing Impairment: Nontestable Patients. Where pure tone audiometry or speech discrimination testing is not available or not reliable because of the patient's age or condition, the attending physician must submit documentation which demonstrates the patient is unable to engage in basic

-Continued-

productive activities of daily living expected of unimpaired persons of the same age group. An example of acceptable documentation would be electrophysiological tests of hearing such as auditory evoked potential testing or a behavioral assessment which shows that, without special help, an infant with a hearing impairment will not develop normal language. Each case will be reviewed on its own merits.

EFFECTIVE DATE November 23, 1983

Subject: PROGRAM FOR THE HANDICAPPED - TRANSPORTATION	Chapter: 8 Section: 3
Authority: DoD 6010.8-R, Chapter V.H.2.o	Page: 3.3.1
Approval: Keith W Cutler Deputy Director	Date: January 23, 1984

POLICY

The reimbursement rate for the use of a privately-owned vehicle in both a carpooling situation and when only one dependent is being transported is 15 1/2 cents per mile or actual transportation costs, whichever is lower.

Transportation by means other than a privately-owned vehicle will be reimbursed on the basis of actual ticket costs.

Revision No:	Revision Date:

Subject: VISUAL IMPAIRMENT: PROGRAM FOR THE HANDICAPPED	Chapter: 8 Section: 3
Authority: DoD 6010.8-R, Chapter V.E.2.b.	Page: 3.4.1
Approval: Keith W Curtis Deputy Director	Date: January 23, 1984

POLICY	If a child under age seven has a visual impairment which is not part of an overall medical condition and has no other handicap, a medical statement and management plan signed by a physician is not required in order to apply for benefits in connection with optometric evaluation under the Program for the Handicapped. An optometrist may perform vision testing without a physician referral.
POLICY CONSIDERATIONS	The exception for physician referral and management plan applies only to children under age seven.

Subject: OCCUPATIONAL THERAPY	Chapter: 8 Section: 4
Authority: DoD 6010.8-R, Chapter IV, C.3.j.	Page: 4.1.1
Approval: Robert D Seaman for Director	Date: December 5, 1984

DESCRIPTION	Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, improving the individual's ability to perform those tasks required for independent functioning.
POLICY	Occupational therapy services provided on an inpatient or outpatient basis by an employee of a CHAMPUS-authorized institutional provider as part of an organized rehabilitation program is covered.
EFFECTIVE DATE	November 13, 1984
EXCEPTIONS	Cardiac rehabilitation centers are not recognized by CHAMPUS as authorized providers. (See Chapter 1, Section 18, Page 93797.1.1 of this Volume One.)
POLICY CONSIDERATIONS	1. In order to be covered, occupational therapy must be prescribed by a physician. For occupational therapy provided to a patient with a mental disorder, the therapy must be prescribed by a qualified mental health provider. 2. The types of services ordinarily provided in occupational therapy include: a. Evaluation of a patient's level of functioning by administering diagnostic and prognostic tests.

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b. Selection and teaching of task-oriented therapeutic activities designed to restore physical function.

c. Planning, implementing, and supervising individualized therapeutic activity programs as an integral part of an overall "active treatment" program for a patient with a mental disorder.

d. Teaching compensatory techniques to improve the level of independence in the activities of daily living.

e. Designing, fabricating, and fitting of orthotic and self-help devices.

f. Vocational and prevocational assessment and training.

3. The services listed above are coverable only when there is an expectation that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. If the expected level of improvement is insignificant in relation to the extent and duration of therapy, the therapy is not coverable.

4. Where vocational or prevocational assessment or training relates primarily to specific employment opportunities, or work skills or work settings, the services are not covered. Payment may be made for services rendered as an integral part of an overall rehabilitation effort to assess level of functioning and to teach compensatory skills.

5. Occupational therapists are not recognized as individual professional providers by the Regulation and will not be

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paid on a fee-for-service basis for services provided to CHAMPUS beneficiaries. All such services must be billed for by the CHAMPUS-authorized institutional provider that employs the occupational therapist. The CHAMPUS beneficiary must be involved in an organized rehabilitation program designed to restore or improve functions lost or impaired by illness or injury. Inpatient therapeutic activity programs for patients with mental disorders are covered, provided the therapeutic relationship between the activities and the patient's condition is documented.

6. Occupational therapy provided on an outpatient basis for longer than a 60-day period or more frequently than twice a week requires documentation of the medical necessity for the therapy, a statement of the goals of treatment, and the expectations regarding outcomes of the therapy.

Subject: PRIVATE DUTY NURSING: HOSPITAL WITH SPECIALIZED ICU	Chapter: 8 Section: 5
Authority: DoD 6010.8-R, Chapter IV.C.3.o.	Page: 5.1.1
Approval: Deputy Director	Date: January 23, 1984

DESCRIPTION

A specialized ICU is a separate ICU maintained for a specific type of medical condition such as respiratory conditions. cardiac surgery, coronary care, burn care, pediatrics or neurosurgery.

POLICY

If a hospital has only a specialized ICU but no ICU level for other medical conditions, the services of a private duty nurse may be covered when an intensive level of skilled nursing care is medically required by the patient and the specialized ICU is not appropriate for the patient's condition.

POLICY CONSIDERATIONS

When the hospital has an ICU which is available to all patients whose medical condition requires an intensive level of skilled nursing care, or has a specialized ICU which is appropriate for the patient's condition, no CHAMPUS benefits are available for private duty nursing.

Private duty nursing is not covered in a hospital with a general ICU, or a specialized ICU which meets the patient's needs, even if the ICU is full or the patient is prevented from using it because of a contagious disease.

Subject: PRIVATE DUTY NURSING CARE PROVIDED BY LPN OR LVN	Chapter: 8
	Section: 5
Authority: DoD 6010.8-R, Chapter II, B.142; Chapter IV, C.3.d.; Chapter VI, C.3.(5)	Page: 5.2.1
Approval: Deputy Director	Date: 12Oct89

DESCRIPTION

"Skilled nursing service" means a service which can only be furnished by an RN, LPN or LVN under the supervision of a physician in order to assure the safety of the patient and achieve the medically desired result. Skilled nursing services are other than those services which primarily provide support for the essentials of daily living or which could be performed by an untrained adult with minimum instruction and/or supervision. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings or tracheotomy aspiration and insertion.

POLICY

As long as the service being rendered is a skilled nursing service provided by an LPN or LVN under the supervision of a physician, claims do not need to be developed for the purpose of determining if the services of an RN are available.

ANALYSIS

The Regulation stipulates that the services rendered determine if the claim is covered. Use of an LPN for services within his or her technical proficiency is not precluded. The Regulation provision is not interpreted as an absolute requirement or stipulation that an RN _must_ provide the services or the claim would be denied. The primary intent is that payment only be made for a service that is considered "skilled," as opposed to a sitter type service or a service that can be provided by someone with minimal instruction. The controlling factor is the services which are provided

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not the professional status of the nurse or the condition of the patient. The definition of "skilled nursing services" in Chapter II and classification of RN, LPN and LVN in Chapter VI of the Regulation more clearly shows the intent.

Subject: OBSOLETE AND QUESTIONABLE PROCEDURES AND TESTS	Chapter: 8
	Section: 10
Authority: DoD 6010.8-R, Chapter IV, A.10.	Page: 10.1.1
Approval: Keith W Carter	Date: Dec 29,1982

DESCRIPTION

Obsolete and questionable procedures and tests are those which have either been replaced by more advanced procedures or which require satisfactory justification of medical need.

POLICY

Charges for obsolete and questionable procedures and tests will not be paid routinely.

POLICY CONSIDERATIONS

The obsolete and questionable procedures and tests may be paid for only if the medical need for the procedure is satisfactorily justified by the attending or referring physician or the physician who performs it, as applicable. All claims for the following procedures and tests will be developed and referred for review by the fiscal intermediary medical review department on a prepayment basis:

CPT-4 Code	Procedure
20920	Fascia lata graft; by stripper. (FOR LOWER BACK PAIN)
20922	Fascia lata graft; by incision and area exposure, complex or sheet. (FOR LOWER BACK PAIN)
* 36471	Injection of sclerosing solution, multiple veins. (IF A NORMAL SALINE AND LIDOCAINE SOLUTION) *

-Continued-

CPT-4 Code	Procedure
37616	Ligation, major artery (eg, post-traumatic, rupture); chest. (IF INTERNAL MAMMARY ARTERIES, UNILATERAL OR BILATERAL)
37650	Interruption, partial or complete, of femoral vein, by ligature, intravascular device; unilateral. (FOR POST-PHLEBITIC SYNDROME)
37651	Interruption, partial or complete, of femoral vein, by ligature, intravascular device; bilateral. (FOR POST-PHLEBITIC SYNDROME)
49635	Omentopexy for establishing collateral circulation in portal obstruction.
50420	Nephropexy, fixation or suspension of kidney (separate procedure).
52500	Transurethral resection of bladder neck (separate procedure). (FOR FEMALES)
57520	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair. (FOR CHRONIC CERVICITIS)
58180	Supracervical hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s).

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CPT-4 Code	Procedure
58400	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure).
58410	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy.
64809	Sympathectomy, thoracolumbar; unilateral. (FOR HYPERTENSION)
64811	Sympathectomy, thoracolumbar; bilateral. (FOR HYPERTENSION)
64814	Sympathectomy, hypogastric or presacral neurectomy (separate procedure).
64818	Sympathectomy, lumbar; unilateral. (FOR HYPERTENSION)
64819	Sympathectomy, lumbar; bilateral. (FOR HYPERTENSION)
67510	Retrobulbar injection; air or opaque contrast medium for radiography.
74720	Radiologic examination, abdomen, for fetal age, fetal position and/or placental localization; single view. (FOR FETAL AGE)

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CPT-4 Code	Procedure
74730	Placentography with contrast cystography; supervision and interpretation only.
74731	Placentography with contrast cystography; complete procedure.
74770	Radiologic examination, fetal study, intrauterine contrast visualization; supervision and interpretation only.
74771	Radiologic examination, fetal study, intrauterine contrast visualization; complete procedure.
75505	Angiocardiography by serialography, single plain; supervision and interpretation only.
75507	Angiocardiography by serialography, multi-plane; supervision and interpretation only.
75510	Angiocardiography, CO_2 or positive contrast, intravenous, for pericardial effusion or atrial wall thickness; supervision and interpretation only.
75511	Angiocardiography, CO_2 or positive contrast, intravenous, for pericardial effusion or atrial wall thickness; complete procedure
75658	Angiography, brachial, retrograde; supervision and interpretation only.

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CPT-4 Code	Procedure
75710	Angiography, extremity, unilateral; supervision and interpretation only.
75750	Angiography, coronary, root injection; supervision and interpretation only.
75751	Angiography, coronary, root injection; complete procedure.
78401	Cardiac blood pool imaging; (eg, pericardial effusion).
82155	Amylase, serum; isoenzymes, electrophoretic.
82345	Calcium, feces, quantitative, timed specimen.
82490	Chromium; blood.
82505	Chymotrypsin, duodenal contents.
83005	Guanase, blood.
83533	Iodine; protein bound (PBI).
83870	Mucoprotein, blood (seromucoid).
83974	Pepsin, gastric.
84317	Starch, feces, screening.
84645	Zinc sulfate turbidity.
84999	Diagnex Blue, tubeless gastric.
85150	Calcium clotting time.

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CPT-4 Code	Procedure
85160	Calcium saturation clotting test.
85165	Capillary fragility test, Rumpel-Leede (separate procedure).
86450	Skin test; actinomycosis.
86470	Skin test; brucellosis.
86480	Skin test; cat scratch fever.
86520	Skin test; leptospirosis.
86530	Skin test; lymphogranuloma (lymphopathia) venereum (Frei test).
86550	Skin test; psittacosis.
86570	Skin test; trichinosis.
87300	Vaccine, autogenous.
89080	Colloidal gold, spinal fluid.
89399	Basal metabolic rate (BMR).
93201	Phonocardiogram with ECG lead; with supervision during recording with interpretation and report (when equipment is supplied by the physician.
93202	Phonocardiogram with ECG lead; tracing only, without interpretation and report (when equipment is supplied by the hospital, clinic, etc).
93204	Phonocardiogram with ECG lead; interpretation and report.

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CPT-4 Code	Procedure
93205	Phonocardiogram with ECG lead, with indirect carotid artery and/or jugular vein tracing, and/or apex cardiogram; with interpretation and report.
93208	Phonocardiogram with ECG lead, with indirect carotid artery and/or jugular vein tracing, and/or apex cardiogram; tracing only without interpretation and report.
93209	Phonocardiogram with ECG lead, with indirect carotid artery and/or jugular vein tracing, and/or apex cardiogram; interpretation and report only.
93240	Ballistocardiogram.
93780	Circulation time; one test.
*.....	Bendien's test.
*.....	Bolen's test.
*.....	Bronchoscopic instillation of contrast medium.
*.....	Bronchoscopy; with insertion of radioactive substance.
*.....	Carotid body denervation.
*.....	Cephalin flocculation, blood.
*.....	Circumcision, female.
*.....	Congo red, blood.

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CPT-4 Code	Procedure
*.....	Kidney decapsulation, unilateral.
*.....	Kidney decapsulation, bilateral.
*.....	Excision of carotid body (glomectomy) with or without excision of carotid artery. (FOR OBSTRUCTIVE PULMONARY DISEASE)
*.....	Fabric wrapping of abdominal aneurysm.
*.....	Galvanic iontophoresis.
*.....	Gastric freezing.
*.....	Hair analysis test.
*.....	Hormones, adrenocorticotropin quantitative animal tests.
*.....	Hormones, adrenocorticotropin quantitative bioassay.
*.....	Hysterotomy, nonobstetrical, vaginal approach.
*.....	Icterus index, blood.
*.....	Ligation of thyroid arteries (separate procedure).
*.....	Perirenal insufflation.
*.....	Prolotherapy.
*.....	Rehfuss' test.
*.....	Serum seromucoid assay.

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*..... Splanchnicectomy, unilateral.
(FOR HYPERTENSION)

*..... Splanchnicectomy, bilateral.
(FOR HYPERTENSION)

*..... Thymol turbidity, blood.

*..... Vineburg procedure.

* - Procedure code not listed in CPT-4

Subject: SERVICES RENDERED BY EMPLOYEES OF AUTHORIZED INDEPENDENT PROFESSIONAL PROVIDERS	Chapter: 8 Section: 11
Authority: DoD 6010.8-R, Chapter VI, E.2.	Page: 11.1.1
Approval: Keith W Curtis	Date: APR 19 1983

DESCRIPTION

Services commonly furnished by employees in physicians' offices or clinics which are either rendered without charge or included in the physicians' bills are referred to as services furnished incident to a physician's professional services. This means that the services are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

POLICY

Services rendered by employees (i.e., aides, technicians, attendants, etc.) of an authorized independent individual professional provider (hereafter referred to as an authorized provider) are subject to the following criteria:

1. The individual must be an employee for whom the authorized provider, as employer, pays a salary, Social Security taxes, Workmen's Compensation, etc.

2. The services must be performed under the authorized provider's direct personal supervision. Direct personal supervision in the office setting does not mean that the physician must be present in the same room with the aide, but must be present in the office suite and immediately

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available to provide personal assistance and direction throughout the time the employee is rendering the services. Availability of the provider by telephone does not constitute direct, personal supervision.

3. The authorized provider must bill for the services rendered by the employees. Such charges represent an overhead expense incurred by the provider in his or her professional practice and are covered, as such, within the allowable charge determination.

4. The services rendered must be otherwise covered, and not of a type usually performed only by a physician or other authorized provider; e.g., minor surgery performed by a physician assistant would be excluded even if performed under the direct supervision of a physician.

POLICY CONSIDERATIONS

There are occasions when services provided, by the employee, in a setting outside the private practice setting, such as in a hospital or in a home, may be covered. These services must also be provided under the direct supervision of the authorized provider.

This means that in the hospital setting, the authorized provider is not required to be physically present at all times, but must be close by and available to provide immediate and personal assistance and

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direction. In the home setting, the authorized provider's presence is required for the employees' services to be covered. (Only services by authorized providers, such as nurses, may be approved when provided in the home without a physician present).

Examples of out of office settings include:

a. A nonphysician anesthetist who is an employee of an authorized provider (anesthesiologist, surgeon or other physician), and who provides anesthesia services in the hospital setting.

b. A perfusionist who is an employee of an authorized provider (physician) and who is attending with the provider at cardiac surgery in the hospital setting.

c. Services provided by employees (aides or technicians) who accompany the physician on a house call may be covered. (Services will not be covered if the aide or technician makes the call without the physician).

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6010.47-M

Subject: WIGS OR HAIRPIECES	Chapter: 8 Section: 12
Authority: Defense Appropriation Act, Fiscal Year 1983	Page: 12.1.1
Approval: Keith W Curtis	Date: APR 19 1983

DESCRIPTION

The Defense Appropriation Act for fiscal year 1982 and the Continuing Resolution for fiscal year 1983 authorize CHAMPUS coverage of a wig or hairpiece when hair loss occurs as a result of treatment of a malignant disease.

POLICY

CHAMPUS will provide coverage for one wig or hairpiece for a beneficiary who has experienced hair loss as a result of the treatment of a malignant disease. Only one wig or hairpiece will be covered in the beneficiary's lifetime. This will be provided only if the beneficiary has not previously received a wig or hairpiece through the United States Government (for example, the Veterans' Administration).

EFFECTIVE DATE

December 15, 1980.

POLICY CONSIDERATIONS

1. Claims documentation. Claims must be supported by the following documentation:

a. A statement from the attending physician certifying that alopecia has resulted from treatment of a malignant disease; and

b. A statement from the beneficiary (or sponsor) certifying that a wig or hairpiece has not previously been obtained through the United States Government.

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Revision No: Revision Date:

2. Allowable Charge. The CHAMPUS-determined allowable charge may not exceed $250 per wig or hairpiece. If the wig or hairpiece purchased by the beneficiary exceeds this maximum amount, CHAMPUS can only cost-share up to the allowable amount.

3. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

a. Alopecia resulting from conditions other than treatment of malignant disease.

b. Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

c. Hair transplants or any other surgical procedure involving the attachment of hair or a wig hairpiece to the scalp.

d. Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

Subject: EATING DISORDERS	Chapter: 8 Section: 13
Authority: DoD 6010.8-R, Chapter IV, C.3.i	Page: 13.1.1
Approval: Deputy Director	Date: 19 July 1983

DESCRIPTION

The following diagnoses are considered by the Diagnostic and Statistical Manual of Mental Disorders -- Third Edition (DSM-III) to be eating disorders:

Anorexia Nervosa (307.10)
Bulimia (307.51)
Pica (307.52)
Rumination Disorder of Infancy (307.53)
Atypical Eating Disorder (307.50)

POLICY

A claim for treatment of a DSM-III eating disorder diagnosis is to be adjudicated as a mental health claim.

POLICY CONSIDERATIONS

1. The term "eating disorder" is not a medical diagnosis.

2. Inpatient and outpatient claims for services and supplies (otherwise authorized by the CHAMPUS) provided within an eating disorder program operated by a CHAMPUS authorized institutional provider may not be denied solely on the basis that the services were provided in an eating disorder program.

UTILIZATION REVIEW

See the OCHAMPUS Policy Manual (6010.47-M) Volume II, Appendix "A" for guidance.

NOTE

This guidance is a clarification of guidance on eating disorder programs initially issued on July 19, 1983. Additional guidance on eating disorder programs is at Vol.II, Chap. 2, Sec. 1, Page 1.3.1.

Revision No: 2 Revision Date: February 26, 1986

Subject: INVESTIGATIONAL OR EXPERIMENTAL PROCEDURES	Chapter: 8 Section: 14
Authority: DoD 6010.8-R, Chapter IV, G. 15.	Page: 14.1.1
Approval: Deputy Director	Date: November 1, 1983

POLICY

1. Services and supplies considered to be investigational or experimental are excluded from CHAMPUS coverage.

2. This exclusion includes all services directly related to the experimental or investigational procedure.

POLICY CONSIDERATIONS

The following is a partial list of investigational or experimental procedures which do not qualify for benefits under CHAMPUS. This list is for example purposes only, and is not to be construed as being all inclusive.

1. Radial keratotomy (refractive keratoplasty). See Volume One, Chapter 3, Section 16, page 66999.1.1, of the Policy Manual.

2. Dorsal column and deep brain electrical stimulation for the treatment of motor function disorders. (See Chapter 3, Section 15, Page 61850.1.1 of this Volume One.)

3. Chelation therapy, except under specific conditions. See Chapter 1, Section 11, Page 90784.1.1 of this Volume One.

4. Cochlear implants.

5. In vitro fertilization.

6. Cellular therapy.

7. Histamine therapy.

-Continued-

8. All organ transplants except kidney, some bone marrow (See Chapter 5, Section 5, page 85120.1.1), liver, corneal, heart-valve, and skin grafts (subject to the provisions of DoD 6010.8-R, Chapter 4, Section E.8.).

9. Plasmapheresis, except for the conditions outlined in Volume One, Chapter 5, Section 6, page 86389.1.1, of the Policy Manual.

10. Implantable infusion pumps, except as authorized in Chapter 3, Section 5, Page 36260.1.1 of this Volume One. See Chapter 7, Section 3, page 3.10.1 of this Volume for policy concerning portable infusion pumps.

11. Stem Cell Assay, a laboratory procedure which allows a determination to be made of the type and dose of cancer chemotherapy drugs to be used, based on in vitro analysis of their effects on cancer cells taken from an individual. The efficacy of this test is not established by scientific data and it does not reflect a standard laboratory procedure provided in the United States.

12. Transurethral ureteroscopic lithotripsy (transurethral nephrolithotomy). See Volume One, Chapter 3, Section 9, Page 50087.1.2.

13. Topical Application of Oxygen. The clinical efficacy of oxygen by topical application has not been established and is considered investigational.

14. Immunotherapy for malignant disease. See Chapter 1, Section 11, Page 90788.1.1 of this Volume One.

-Continued-

15. Prolotherapy, joint sclerotherapy, and ligamentous injections with sclerosing agents.

16. Botulinum Toxin A injections. See Chapter 1, Section 11, Page 90782.1.1 of this Volume One.

17. Transcervical block silicone plug. See Chapter 7, Section 4, Page 4.2.1 of this Volume One.

* 18. Chorion Villus Sampling (CVS). Safety and accuracy of this method of detecting fetal abnormalities is still under investigation by clinical trials. *

19. Whole body hyperthermia in the treatment of cancer.

20. Intensive inpatient EEG video monitoring.

21. Automatic implantable defibrillators.

22. Portable nocturnal hypoglycemia detectors.

23. Testosterone pellet implants.

24. Estradiol pellet implants.

25. Epikeratophakia for treatment of aphakia and myopia.

26. Streptokinase (SK) infusion for acute myocardial infarction.

27. Anterior cruciate reconstruction done arthroscopically.

-Continued-

28. Molteno implant.

29. Bladder stimulators. (See Chapter 3, Section 9, Page 53899.1.1 of this Volume I.)

Subject: MEDICAL PHOTOGRAPHY	Chapter: 8 Section: 15
Authority: DoD 6010.8-R, Chapter IV. G.78	Page: 15.1.1
Approval: Keith W Deputy Director	Date: January 23, 1984

POLICY	Services of a Medical Photographer are not covered even when photographs are required to make a benefit determination.

Revision No:	Revision Date:

Subject: LIQUID PROTEIN DIETS	Chapter: 8
	Section: 16
Authority: DoD 6010.8-R, Chapter IV.E.9. & IV.G.28.	Page: 16.1.1
Approval: Keith W Curtis Deputy Director	Date: January 23, 1984

DESCRIPTION	Protein sparing fast diets using predigested protein.
POLICY	Nonsurgical treatment of obesity, morbid obesity, dietary control or weight control is not covered. Therefore, any charges associated with the liquid protein diet are not covered which includes the cost of the predigested protein, physician's visits and any testing performed in relation to the diet.
POLICY CONSIDERATIONS	Treatment of complications as a result of the diet are subject to the regulatory provisions on complications from noncovered treatment.

Revision No: Revision Date:

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6010.47-M

Subject: STANDBY CHARGES	Chapter: 8 Section: 17
Authority: DoD 6010.8-R, Chapter IV.C.2.1	Page: 17.1.1
Approval: Deputy Director	Date: FEB 14 1984

DESCRIPTION

A standby charge is a charge made by an individual provider to cover the expenses involved in maintaining a ready or available status in the event the services the provider has to offer may be required.

POLICY

Pediatric services of a standby physician are covered under the following conditions:

1. For delivery by cesarean section or for a vaginal delivery when there is a reasonable expectation of fetal distress;

2. The standby physician is physically present during the delivery; and

3. The standby physician has the qualifications necessary to resuscitate newborn infants.

POLICY CONSIDERATIONS

Claims for standby pediatric services must include a statement from the standby physician which:

1. Documents the situation requiring the presence of the standby physician, and

2. Provides the name and address of the attending obstetrician.

EXCEPTIONS

Coverage for standby charges is limited to the conditions outlined above. Standby charges related to any other circumstance are not covered.

Revision: Revision Date:

Subject: AMINO ACID MODIFIED PRODUCTS FOR INBORN ERRORS OF AMINO ACID METABOLISM	* Chapter: 8 *
	* Section: 18 *
Authority: DoD 6010.8-R, Chapter IV, D.3.f.	* Page: 18.1.1 *
Approval: Keith W Carter	Date: APR 19 1983

DESCRIPTION

The aminoacidopathies, consisting of phenylketonuria, maple syrup urine disease, homocystinuria, histidinemia and tyrosinemia, are rare genetic diseases which may be treated by the dietary restriction of one or more amino acids. Untreated, these diseases culminate in death or severe mental retardation.

POLICY

Special amino acid modified nutrient preparations for patients with inborn errors of amino acid metabolism are covered on the same basis as insulin for diabetic patients when a prescription is not required. The product must be accepted by the general medical community as essential to the management of the patient's condition.

POLICY CONSIDERATIONS

The claim must be accompanied by a statement from the attending physician which documents the patient's medical condition. The patient must be under the close supervision of a physician.

Revision No: Revision Date:

Subject: TRANSTELEPHONIC MONITORING OF PACEMAKERS	Chapter: 8 Section: 19
Authority: DoD 6010.8-R, Chapter IV, G.58.	Page: 19.1.1
Approval: Deputy Director	Date: 12 Oct 84

DESCRIPTION

Transtelephonic monitoring of cardiac pacemakers is a convenient and effective means of alerting the physician to incorrect positioning or malfunctioning of the electrodes, failure of the generator's electronic circuitry and impending battery exhaustion. This method serves to increase patient comfort and to reduce the cost of medical care.

POLICY

Benefits should be provided for transtelephonic monitoring of pacemakers as a complement to outpatient visits to a physician's office or specialized cardiac unit in a hospital or clinic. The following guidelines should be used to screen claims for transtelephonic monitoring of pacemakers prior to payment.

1. Mercury-zinc battery powered pacemaker:

   a. Both pacemaker and lead implanted:

   1st month - once per week

   2nd through 15th month - once every 4 weeks

   16th through 18th month - every 2 weeks

   19th month through to failure - once per week

   b. Only pacemaker implanted, lead not changed:

   1st 2 weeks - once per week

-Continued-

Revision No: Revision Date:

3rd week through 15th month - once every 4 weeks

16th through 18th month - every 2 weeks

19th month through to failure - once per week

2. Lithium battery powered pacemakers:

a. Both pacemaker and lead implanted:

1st month - once per week

2nd month through to failure - once every 4 weeks

b. Only pacemaker implanted, lead not changed:

1st 2 weeks - once per week

3rd week through to failure - once every 4 weeks

These guidelines constitute the maximum frequency for which payment may be made without further development. If further development is required written justification will be requested from the physician or monitoring service. A medical judgement will be made on a case by case basis as to whether more frequent monitoring is medically necessary.

EFFECTIVE DATE	September 13, 1984
POLICY CONSIDERATIONS	The charge from an otherwise authorized provider must represent the total charge for the monitoring service. This includes charges for use of the transmitting device,

-Continued-

monitoring of the patient's pulse and interpretation and report by the cardiologist. Services involving use of telephonic monitoring equipment by a physician or his staff will also be covered as a benefit.

The CHAMPUS-approved procedural code for payment of transtelephonic monitoring of cardiac pacemakers is CPT-4 93796. (See COM-FI(M), Part Three, Chapter 4, Addendum J, Table 6.)

Subject: COURT-ORDERED CARE	Chapter: 8 Section: 20
Authority: DoD 6010.8-R, Chapter IV, G.22.	Page: 20.1.1
Approval: Deputy Director	Date: 5 Dec 84

DESCRIPTION

Court-ordered care is medical service, including inpatient admissions, that a court of law orders or directs a party in a legal proceeding to obtain.

POLICY

The fact that medical services are ordered by a court for a CHAMPUS beneficiary does not determine the benefits available under CHAMPUS. CHAMPUS benefits will be paid only if the service is medically or psychologically necessary to diagnose or treat a covered condition, if the service is at the appropriate level of care to treat the condition, and if the beneficiary (or the beneficiary's family) has a legal obligation to pay for the service.

EFFECTIVE DATE

November 13, 1984

POLICY CONSIDERATIONS

The most common CHAMPUS cases with court involvement are admissions to residential treatment and alcohol treatment programs. Reviewers should be particularly alert to the possiblity of court involvement in these types of cases.

If it is determined that court-ordered care meets the criteria of necessity and appropriateness and, therefore, is potentially payable, the issue of the beneficiary's legal obligation to pay for the care requires specific investigation.

-Continued-

If the care was ordered, or if the patient was directed to a specific treatment provider, primarily because of the potential for CHAMPUS coverage, benefits are not payable. For example, if a public treatment program is available at no cost to the beneficiary, but the court orders or agrees to treatment by a private provider because the patient is a CHAMPUS beneficiary, no benefits may be paid.

Subject: ALCOHOLISM	Chapter: 8
	Section: 21
Authority: DoD 6010.8-R, Chapter IV, E.4.	Page: 21.1.1
Approval: Deputy Director	Date: December 5, 1984

DESCRIPTION

Alcoholism coverage under CHAMPUS, as recently amended, establishes a benefit for the detoxification and treatment of alcoholism, separate from the mental health benefits.

POLICY

CHAMPUS will cover emergency and inpatient hospital care for complications of alcoholism and detoxification (7 days) just as for any other medical condition. CHAMPUS benefits may also be extended for rehabilitation (up to a maximum of 21 days) provided in an authorized alcohol rehabilitation facility, subject to a limit of 3 benefit periods in a lifetime. The extent of coverage in each benefit period is limited to 21 days of rehabilitation (either inpatient or partial hospitalization), 60 visits for outpatient treatment and 15 visits for family therapy.

EFFECTIVE DATE

November 13, 1984

EXCEPTIONS

1. Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol or other drugs as negative reinforcement is not covered, even if recommended by a physician. All professional and institutional charges associated with a rehabilitation treatment program that uses aversion therapy must also be denied. FIs shall request itemized billings for those facilities that are known to utilize aversion therapy and are currently reimbursed on an all-inclusive rate. This step is necessary to ensure program payment is not inadvertently bein made for aversion therapy (see COMPFI, Pa 2, II.B.7.b.).

-Continued-

2. Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers. Charges for services provided by these facilities are not covered.

3. Partial hospitalization for other than alcoholism. Claims for partial hospitalization for other than alcoholism shall be denied.

POLICY CONSIDERATIONS

1. Detoxification and rehabilitation. CHAMPUS allows up to 21 days per year, plus 7 days for detoxification. If the detoxification is in an inpatient hospital facility and goes beyond 7 days, the claim is subject to review for medical necessity. Stays for detoxification in an alcohol rehabilitation facility are covered up to a maximum of 7 days. The combination of detoxification and rehabilitation can equal 28 days.

2. Repeated admissions for detoxification. Although there is no absolute limit on the number of admissions for detoxification, repeated admissions should be closely monitored to ensure that the inpatient level of care is medically required and to rule out domiciliary type
* care. These days, in addition to inpatient*
rehabilitation treatment days, must be
counted toward the 60-day mental health
* inpatient limit (see Volume I, Section 12,*
* page 12.1.1 of the Policy Manual). *

* 3. Partial hospitalization (92891-92893).*
Rehabilitative care in an authorized
alcohol rehabilitation facility is covered
in a partial hospitalization setting.
Coverage is limited to no more than 21 day
* in a benefit period. (NOTE: The

-Continued-

beneficiary may have either 21 days of rehabilitation on an inpatient basis or 21 days of rehabilitation in a partial hospitalization setting, or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.) Partial hospitalization is subject to outpatient cost-sharing provisions and is not counted toward the 60-day mental health inpatient limit.

4. Benefit period. A benefit period begins with the first day of rehabilitation and ends 365 days later. Unused benefits cannot be carried over to subsequent benefit periods.

5. Alcoholism counselors. Services may be provided by alcoholism counselors when rendered by a CHAMPUS-authorized alcohol rehabilitation facility and when the cost of the services is included in the facility's CHAMPUS-determined allowable cost rate.

6. Confidentiality. See COM-FI, Part 2, Chapter 1, Section VII.C.

Subject: FAMILY PLANNING	Chapter: 8
	Section: 22
Authority: DoD 6010.8-R, Chapter IV.E.3.	Page: 22.1.1
Approval: Robert D. Seaman for Director	Date: August 26, 1985

POLICY

Benefits may be provided for birth control services and supplies only as specifically listed below:

1. Surgical insertion, removal, and replacement of intrauterine devices.
2. Measurement for, and purchase of, contraceptive diaphragms (and remeasurement and replacement).
3. Prescription oral contraceptives.
4. Surgical sterilization.

EXCEPTIONS

The family planning benefit does not include routine gynecologic examinations, PAP smears, or any related laboratory testing for an asymptomatic patient.

APPENDIX

APPENDIX A

The following OCHAMPUS issuances are superseded by the CHAMPUS Policy Manual:

CHAMPUS Interim Instruction 13-77	Laetrile, dated August 2, 1977.
CHAMPUS Interim Instruction 13-78	CHAMPUS Regulation DoD 6010.8-R: Interpretations 13-78-I through 22-78-I, and 07-78-I (Revised), dated March 22, 1978.
CHAMPUS Interim Instruction 37-78	CHAMPUS Regulation DoD 6010.8-R: Interpretations 24-78-I through 31-78-I, dated September 1, 1978.
OCHAMPUS Instruction 6010.5	Alcoholism, dated May 8, 1981.
OCHAMPUS Instruction 6010.10	Conjoint Therapy and Collateral Visits dated June 3, 1981.
OCHAMPUS Instruction 6010.15	Sexual Dysfunctions and Sexual Inadequacy, dated June 9, 1981.
OCHAMPUS Instruction 6010.16	Insulin Injectors Without a Needle, dated June 3, 1981.
OCHAMPUS Instruction 6010.2	Home Oxygen Therapy, May 6, 1980.
OCHAMPUS Instruction 6010.25	"At Home" Blood Glucose Monitors, dated October 30, 1981.
OCHAMPUS Instruction 6010.3	Computed Tomography Scanning, dated March 14, 1980.
OCHAMPUS Instruction 6010.31	Well-Baby Care, CHAMPUS Share Limit - Program for the Handicapped, dated September 22, 1980.
OCHAMPUS Instruction 6010.32	Wigs/Hairpieces, dated December 18, 1981.
OCHAMPUS Instruction 6010.34	**Radial Keratotomy, dated April 16, 1981.**
OCHAMPUS Instruction 6010.35	Home Parenteral Nutrition Therapy, dated November 10, 1981.
OCHAMPUS Instruction 6010.37	Department of Defense Appropriation Act, 1981, dated March 17, 1981.
OCHAMPUS Instruction 6010.38	Service Connected Disabilities, March 17, 1981.

APPENDIX A (continued)

OCHAMPUS Instruction 6010.40	Mastectomy and Post-Mastectomy Reconstructive Breast Surgery, dated December 18, 1981.
OCHAMPUS Instruction 6010.41	Custodial Provisions, January 12, 1982.
OCHAMPUS Instruction 6010.44	Electric-Powered, Cart-Type Vehicles, dated May 26, 1982.
OCHAMPUS Instruction 6010.45	Plasmapheresis, dated June 28, 1982.
OCHAMPUS Instruction 6010.8	Standby Charges, dated April 16, 1980.
OCHAMPUS Instruction 6010.9	Service Conected Disabilities, dated March 17, 1981.
Interpretation 01-77-I	Natural Child Birth Classes, dated August 16, 1977.
Interpretation 02-77-I	Orthokeratology, dated August 21, 1977.
Interpretation 06-77-I	Denis-Browne Splint, dated December 1, 1977.
Interpretation 09-77-I	Availability of CHAMPUS Benefits in Certain Non-Authorized Hospitals, dated August 29, 1977.
Interpretation 10-77-I	Rabies Injections: Veterinarian's Fee, dated August 29, 1977.
Interpretation 11-77-I	Lenses, dated December 1, 1977.
Interpretation 12-77-I	Punctum Plug, dated December 1, 1977.
Interpretation 13-77-I	Complications of Pregnancy, dated December 1, 1977.
Interpretation 14-77-I	Routine Screening Procedures, dated December 1, 1977.
Interpretation 16-77-I	Maternity Episode: Prescription Drugs, December 1, 1977.
Interpretation 20-77-I	Private Duty Nursing, dated December 1, 1977.
Interpretation 26-77-I	Consultations: Written Report, dated December 1, 1977.
Interpretation 29-77-I	Medical Photography, dated Decenber 6, 1977.

APPENDIX A (continued)

Interpretation 30-77-I	Emergency Room Charges: Subsequent, Inpatient Admission, dated December 7, 1977.
Interpretation 35-77-I	Biofeedback, dated December 13, 1977.
Interpretation 36-77-I	PFTH: Transportation, dated December 14, 1977.
Interpretation 37-77-I	Psychotherapy: Inpatient, dated December 1, 1977.
Interpretation 38-77-I	Eye Examinations, dated December 19, 1977.
Interpretation 39-77-I	Hospital Admission: Routinely Required Chest X-Rays and/or Electrocardiograms, dated December 20, 1977.
Interpretation 43-77-I	Home Health Agencies, dated December 23, 1977.
Interpretation 44-77-I	Hospital: Late Discharge, dated December 28, 1977.
Interpretation 45-77-I	Orthopedic Braces, dated December 28, 1977.
Interpretation 46-77-I	Maternity Care: Need for Nonavailability Statements, dated December 29, 1977.
Interpretation 02-78-I	Liquid Protein Diets, dated January 6. 1978.
* Interpretation 03-78-I *	Peripheral Electrical Nerve Stimulation, dated January 10, 1978. * *
* Interpretation 04-78-I *	Central Column Nerve Stimulators dated Januray 11, 1978. * *
Interpretation 05-78-I	Vitamin B-12 Injections, dated January 12, 1978.
Interpretation 06-78-I	Infant of Unmarried Dependent, dated January 13, 1978.
Interpretation 08-78-I	Ambulance Service, dated January 19, 1978.
Interpretation 09-78-I	Ambulance Service: Charges, dated January 24, 1978.

APPENDIX A (continued)

Interpretation 11-78-I	Nurse Anesthetists, dated January 27, 1978.
Interpretation 12-78-I	Replacement of Prosthesis, dated January 30, 1978.
Interpretation 13-78-I	Psychosurgery, dated February 1, 1978.
Interpretation 14-78-I	Natural Childbirth, dated February 2, 1978.
Interpretation 17-78-I	Complications Arising from Non-Covered Initial Surgery, dated February 10, 1978.
Interpretation 15-78-I	Speech Therapy, dated February 6, 1978.
Interpretation 16-78-I	Hearing Aids, dated February 9, 1978.
Interpretation 18-78-I	Anesthesia administered by Attending Physician, dated February 15, 1978.
Interpretation 20-78-I	Tubal Ligation, dated February 19, 1978.
Interpretation 22-78-I	Orthodontia related to Scoliosis, dated February 25, 1978.
Interpretation 23-78-I	Noncovered Dental Care: Hospital Setting Medically Required, dated March 16, 1978.
Interpretation 24-78-I	Support Hose, dated August 4, 1978.
Interpretation 25-78-I	Repair of Durable Medical Equipment, dated August 11, 1978.
Interpretation 27-78-I	Dialysis in Connection with Schizophrenia, dated August 16, 1978.
Interpretation 28-78-I	Photochemotherapy: Treatment for Psoriasis, dated August 17, 1978.
Interpretation 29-78-I	Half-Way House, dated August 18, 1978.
Interpretation 30-78-I	Marathon Therapy, dated August 21, 1978.
Interpretation 31-78-I	Mental Health Services: Chemotherapy Management, dated August 22, 1978.
Interpretation 32-78-I	Corneal Transplants, dated September 5, 1978.

APPENDIX A (continued)

Interpretation 33-78-I	Ultrasound Diagnostic Procedures, dated September 6, 1978.
Interpretation 34-78-I	PFTH: Visual Impairment, dated September 11, 1978.
Interpretation 36-78-I	Private Duty Nursing, dated September 14, 1978.
Interpretation 38-78-I	Medical Care Provided by Employer at no cost to Employee, dated November 7, 1978.
Interpretation 39-78-I	Bone Marrow Transplants, dated November 14, 1978.
Interpretation 01-79-I	Electronic Cardio-pulmonary Home Monitors, dated June 8, 1979.

All other OCHAMPUS Interim Instructions (CII's dated 1977-1979),OCHAMPUS Instructions (OCI's dated 1980-1982) and OCHAMPUS Regulation Interpretations (dated 1977-1979) not cancelled by Appendix A of the COM-FI(M), or above, will remain in effect until cancelled or reissued in the COM-FI(M) and/or the CHAMPUS Policy Manual.

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